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AN EXPLORATION OF STIGMA TOWARDS DEPRESSION IN RURAL IRELAND: A MIXED METHODS STUDY

A Thesis presented to the University of Dublin, Trinity College for the Degree of Doctor in Philosophy

by

Conor Kennedy

March 2014

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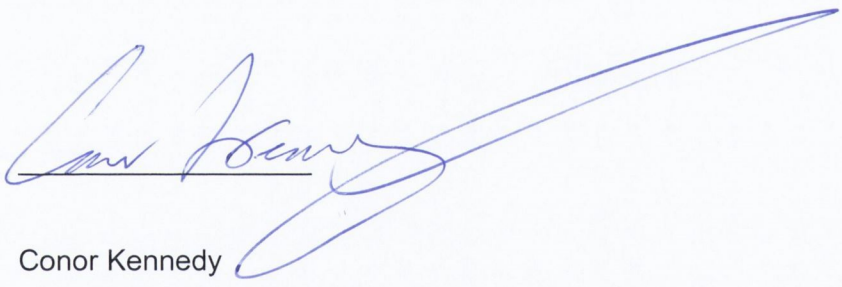

Conor Kennedy

Summary

This research demonstrates that experiencing depression is associated with a perceived expectation of being subject to stigmatisation in rural Ireland. Evidence is presented which suggests core social processes, actioned within this setting and driven by dominant social forces, are conspiring to facilitate the proliferation of this scenario.

Background

The configuration of one's social environment influences the course of depression. Research suggests that experiencing depression is associated with stigmatisation, with this identified as a particularly important factor in rural communities. Stigmatisation is associated with the imposition of discrimination across many facets of social life. Depression is closely linked to suicide, a phenomenon suggested to have increased markedly in Ireland over the past decade, particularly in rural areas, leading to questions as to the social experiences of those with mental illness, particularly depression, in rural settings. While it is understood that a significant stigma exists towards broader mental illness in wider Irish society, contemporary work is absent in relation to understanding the stigma towards depression in rural Ireland, how this manifests and persists, and the impacts it may have upon the arrangement of the social environment for those experiencing the condition in this setting.

Research Question

The central question of this research was to what extent is the experiencing of depression a source of stigmatisation in rural Ireland, what are the driving factors behind this stigmatisation, and what impact is this having upon the opportunity for the gaining of community social support for those experiencing the condition in this setting?

Aim

The overall aim of this qualitatively focused mixed methods research was to explore the stigmatisation of depression and potential social support for those experiencing the condition in rural Ireland. The objectives were to:

- Investigate participants' understandings and experiences of stigma in relation to those experiencing depression in rural Ireland,
- Explore cultural perceptions of stigma in relation to depression in rural Ireland via the determination of the drivers of such stigmatisation,

- Examine participants' views of the potential for the provision of social support to those experiencing depression in rural Ireland.

Methodology

Adopting a mixed social causation and social constructionist worldview, the study aims and objectives were achieved through the implementation of a pragmatic research approach incorporating the application of a qualitatively focused concurrent embedded mixed methods research design. Engaging with a rural Irish sample frame, this design encompassed a single phased data collection approach in which a questionnaire survey was initially employed in order to firstly gain quantitative data, and secondly to facilitate recruitment of participants for the qualitative aspect, within which, adopting an ethnographic outlook focusing upon the perceptions of others attitudes, semi-structured interviews were conducted. A qualitatively driven data analysis was undertaken in which data was integrated and themes were deciphered towards the resolution of the research question.

Results

While a low level of personal stigma may be held, a strong perception that others stigmatise, fear, and desire social distance from those experiencing depression persists. These latter outcomes are seen to be facilitated by a culture of secrecy in which local gossip is a key feature. Evidence suggests that the dominant rigidly conservative rural social environment, the traditional importance of the family and Church in rural life, the courtesy stigmas of mental institutionalisation and suicide, and the social conventions of previous generations in relation to understandings of depression in the community have conspired towards the proliferation of depression stigma in this setting. Opportunity for community social support provision and/or utilization may be seen as ultimately limited as a consequence.

Conclusions

A culturally driven intolerance towards depression is perceived to persist in rural Ireland. Implications include the perpetuation of a cycle of secrecy in relation to depression, the removal of the topic from public discourse and public concern and, consequently, the inhibition and/or withdrawal of potentially beneficial community based social resources.

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Chapter One - Introduction

Introduction

This qualitatively focused mixed methods study explored stigma towards depression in rural Ireland. Evidence is presented to demonstrate that depression is perceived to provoke stigmatisation in rural Irish society. The stigmatisation of depression is deemed as being facilitated by the continued influence of traditionally hegemonic aspects of rural culture and the dominant institutions within rural society which have conspired to both define depression as encompassing deviance, and to create a culture of secrecy in relation to depression in this setting. Unsurprisingly, then, the degraded status of depression is perceived as impacting substantially upon the social lives of those experiencing the condition in this setting.

The original contribution to knowledge of this work lies within its uncovering of the persistence of a perceived culture of intolerance towards depression in rural Ireland, and in its exploration of evidence which suggests that core societal characteristics are aiding the proliferation of depression stigma in this setting. Furthermore, this study also contributes evidence to suggest that the supply and utilisation of key resources of social support are being inhibited by this stigma with implications in terms of social tie formation and maintenance.

This introductory chapter aims firstly to provide an outline of the background to what inspired the undertaking of this study culminating in a detailing of the research problem, purpose, and question. This is followed by the outlining of the study aims and objectives as well as the provision of an insight into the personal factors which provided the author with the impetus for this research endeavour. Next, some projected benefits of this study are suggested, while lastly the structure of the thesis is detailed.

Background and Significance

Suicide

While definitively not the central concern of this study, the grave spectre of suicide upon the Irish social landscape provided significant impetus for the undertaking of this research.

"The single most important mental health/mental health related problem in Ireland" (Chambers 2007, p.22), suicide is reported to have reached epidemic proportions in recent years with a record 527 cases noted as taking place in 2009 with similarly high figures (495 in 2010, 525 in 2011 and 507 in 2012) persisting each year since (Horan 2007, Heavey 2010, CSO 2013, NSRF 2013). Suicide accounts for between 1 and 2 percent of global mortality annually with estimates suggesting that for every completed suicide there are between 150 and 200 attempts (O'Neill 2005, Datta & Frewen 2010b). According to the National Office for Suicide Prevention (2011), a significant proportion of the increase in suicide rates in Ireland may be attributed to the increase of instances among males with this cohort producing suicide rates which are three times that of their female counterparts (Cleary *et al.* 2012). Further, it must be acknowledged that the figures quoted may be only the tip of the iceberg as it is also suggested that historically suicide is underreported in Ireland (McCarthy & Walsh 1975, Felle 2005).

Suicide in rural areas has been described in recent coroner reports as "rampant" with figures from the predominantly rural county of Clare, for example, suggesting that death by persons taking their own lives is three times more prevalent in the county as death as a result of road traffic accidents, the latter being a cause of death which has been the centre of national policy and media attention in recent times (MacConnell & Deegan 2011). This declaration is supported by the National Suicide Research Foundation who found that, in line with research from other countries, higher suicide rates persist in rural Ireland than in urban areas of the country (NSRF 2011).

Depression

The mortality risk by suicide associated with depression is many times the general population risk with recent research using the psychological autopsy technique finding that over half of all people who die in this way meet the criteria for current depressive disorder (Cavanagh *et al.* 2003, Hawton & van Heeringen 2009). Defined by the World Health Organisation (WHO) as a "common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration" (WHO 2010), depression is a leading cause of disability affecting approximately 121 million people worldwide. It is predicted that by 2020, depression will become the second most burdensome chronic condition as

measured by Disability Adjusted Life Years (DALYs) for all ages and both sexes (WHO 2010). In Ireland, though reliable figures from primary care are unavailable, it is broadly estimated that 7.5% of the population suffer from the condition (McKeon 2005). The suggested explanations of the causes of depression span the biological, psychological and social spectrum meaning that the adoption of a holistic, biopsychosocial approach to dealing with the matter is imperative (Wasserman 2006).

According to Goldberg and Goodyer (2005), an individual's social environment influences the course of depression thus this environment merits thorough investigation (Webber *et al.* 2011). The suggestion that depression is the subject of a social stigma is a source of concern due to its facilitation of social exclusion and discrimination which act to limit social support and impede social participation (Reidpath *et al.* 2005, Lasalvia *et al.* 2013).

Durkheim, in his analysis of suicide, placed its understanding firmly within the sociological area of investigation in declaring it the result of "neither...the organic-psychic constitution of the individual nor the nature of the physical environment...(and) consequently, by elimination, it must necessarily depend upon social causes and be in itself a collective phenomenon" (Durkheim 1951, p. 97). Expanding upon this logic, this study aims to examine the prevailing social conditions in relation to a major contributing factor to suicide; the experience of depression.

Research Problem

Discussed in greater detail below, it is suggested that depression is the focus of a social stigma (Sims 1993 , Wolpert 1998, O'Neil 2008, Mac Gabhann *et al.* 2010). This stigma has been shown to negatively influence help-seeking behaviour and contribute to the social isolation of the stigma bearer; contributing to the inhibition of potential recovery and, potentially, to instances of suicide (Byrne 2000, Sirey *et al.* 2001, Eagles *et al.* 2003, Pompili *et al.* 2003, Barney *et al.* 2006). Little or no contemporary consideration of this stigma in a rural Irish context, or of the factors facilitating its proliferation there, exists within the broad discourse on depression stigma thus inhibiting attempts to address this critically important but perennially overlooked public health issue in this setting.

Research Purpose

The primary concern of this research is the exploration of the stigmatisation of depression in rural Ireland.

Research Question

To what extent is the experiencing of depression a source of stigmatisation in rural Ireland, what are the driving factors behind this stigmatisation, and what impact is this having upon the opportunity for the gaining of community social support for those experiencing the condition in this setting?

Research Aims and Objectives

Aims

The overall aim of this qualitatively focused mixed methods research is to explore the stigmatisation of depression in rural Ireland.

Objectives

To achieve this aim, the author endeavoured to meet the following objectives:

- To investigate participants' perceptions, understandings and experiences of stigma in relation to the experiencing of depression in rural Ireland,
- Explore the factors which are perceived to be contributing to depression stigma in this setting,
- To examine participants' views of the potential for the provision of social support to those experiencing depression in rural Ireland.

The study aims and objectives are achieved though the adoption of a pragmatic research approach incorporating the implementation of a qualitatively focused concurrent embedded mixed methods research design in which semi-structured interviews and a questionnaire survey feature.

Selecting the Research Topic – Personal Reflection

Prior to my registration upon the PhD programme, I had been fortunate to travel extensively across the world; a crucially formative element in my personal development, playing a central role in developing my understanding of myself and my views of the world. One of the key aspects to emerge from these experiences was the stimulation of my thinking in relation to culture, both localised and globalised, the instruments of its perpetuation, its influence upon both how people come to think and behave, and how we formulate our understandings of how others do likewise. Further, I also sought to understand the elements which acted towards how I perceived myself to be viewed in the eyes of others; often as a Western tourist, a label that frequently seemed unavoidable.

This period within my life coincided with significant increases in suicide across Ireland, my awareness of this heightened by my connection to my home community which was no exception to others in rural Ireland in the frequent experiencing of the particularly devastating form of grief which accompanies such deaths. The physical and social proximity and often similar demographic profile to myself (young and male) of those who ended their lives brought a natural degree of association, while the apparent relationship with life such individuals held contrasted so drastically with my own at this time that I grappled with comprehending the great waste this represented.

My training in social science had instilled a critical faculty which I applied in my consideration of this phenomenon as I moved to, in the words of an influential former lecturer, 'de-familiarise the familiar' and assess the social factors potentially contributing to this outcome. Cognisant of the linkage between depression and suicide, I was also aware, initially through anecdotal evidence, of the somewhat abnormal treatment of depression in Irish society generally, but particularly within rural communities. The combination of the above personal factors and circumstances ultimately provided the impetus towards my desire to contribute to the amelioration of this situation, and my eventual decision to embark upon an exploration of the stigma towards depression in rural Ireland as is presented hereafter.

Projected Benefits of this Study

In discussing depression, this study deals with a socially sensitive subject matter which, in spite of its common occurrence, may be viewed as veiled in silence both in the academic and wider social arenas. Mindful of the paucity of the discourse in this regard, it is hoped that this study may be beneficial in the following ways:

- By stimulating the open discussion of depression, and indeed wider mental illness, the stigma in existence towards same, and potentially the issue of suicide in rural Ireland.
- By providing a critical assessment of key cultural factors facilitating the proliferation of stigma towards depression.
- By contributing to a re-evaluation of the impact of cultural understandings of depression and their frequent contribution to the proliferation of stigma in this regard.
- By encouraging the acknowledgement of the social environment, social conditions, and thus social actors as key factors to the improvement of outcomes from depression.

Thesis Structure

This thesis is divided into nine chapters; this introductory chapter and eight subsequent chapters. The following chapter presents the theoretical framework of the study and discusses the concepts employed which form the foundations of this research. The third chapter presents a critical review of the extant literature in relation to the central components of this work with studies of international scope considered in conjunction with an emphasis upon relevant work already conducted in Ireland where possible. Chapter four discusses philosophical and methodological issues in relation to this study together with providing details of the implemented study design. Chapters five, six and seven present the findings of the research, a comprehensive critical discussion of which is presented in chapter eight. The final chapter, chapter nine, concludes the study and provides suggestions as to the implications of this research as well as offering recommendations, based upon the evidence presented, in relation to areas including education, policy, and future research.

Chapter Two - Theoretical Concepts

Introduction

The purpose of this chapter is to provide a comprehensive examination of the core theoretical concepts upon which this study is based. In doing so, this chapter aims to provide the foundations upon which the increasingly focused and topic specific discussions contained within later chapters may be constructed.

An overview of the sociology of mental health and illness will be provided with particular mention given to the competing and complimentary perspectives upon social reality within this branch of sociological exploration which are deemed pertinent to the present research endeavour. Critical examinations of the discourses pertaining to stigma, social distance, and social support detailing the origin, evolution of thought and understanding, and contemporary application of such concepts will also be detailed.

Sociology of Mental Health and Illness

According to Aneshensel and Phelan, "mental illness is of interest to sociologists because social arrangements and processes define the very construct of mental illness, shape its occurrence, and channel its consequences" (1999, p. 14). Mindful of this and of the profound impact each of these individual elements hold upon the lives of those affected, their relatives and friends, and indeed the wider community, one may argue that sociological enquiry within the realm of mental health and illness is necessitated primarily to facilitate critical enterprise towards, and the enhancement of, understanding of the social reality of mental illness towards the ultimate amelioration of lived experience.

Outlining the main sociological perspectives in relation to mental health and illness, Rogers and Pilgrim (2010) highlight the lack of boundaries and encourage the recognition of each as an element within the "sedimented layers of knowledge which overlap unevenly in time and across disciplinary boundaries" (2010, p. 11). In keeping with this holistic outlook while outlining earlier variations of such perspectives including "social response" and "sociological psychology" approaches, Horwitz also promotes the synthesis of differing

sociological approaches to mental illness research where "the basic assumptions that underlie each can be reconciled" (1999, p. 72) in order to sufficiently answer set research questions. Acknowledging the considerable impact of critical theory in framing the social environment as a source of influence upon the inner lives of its inhabitants, and social realism in promoting a continued appraisal of the production and transformation of society, the present study leans heavily upon a mixed social causation and social constructivist approach.

Unique in its acceptance of the legitimation of what the other schools of thought may view as the 'construct' of mental illness, social causation may be seen to adopt a pragmatic view. Outlined to great effect in the seminal work of Durkheim for example, this view demands an understanding of the influence of the intricacies of the social environment upon the consciousness of those present within it. Though criticised for doing so, in accepting the 'facts' put forward by the holders of power in relation to mental illness, one may argue that this approach saves time and resources in avoiding public, perhaps futile attacks upon established sources of such fact production. Instead, this approach applies itself to the interrogation of the role played by socially induced stressors in the proliferation of the phenomenon under examination. One may argue further that such an approach, forming an element within the present study, offers a significant opportunity for scrutiny of the facts which it is said to accept. Adopting the language and being immersed within the discourse around said facts, commentators become more enabled to provide more comprehensive critiques of same, thus using the power of the discourse and the mechanisms by which this power is continually recycled and renewed to facilitate change.

A reaction against positivism and intimately linked with the core theoretical components of symbolic interactionism discussed below, social constructivism refutes notions which suggest reality as a self-evident entity, instead holding the social environment to be engineered by the thinking and activities associated with human habitation and progress. The linkage between this thinking and that of social causation is facilitated by three aspects of social constructivism outlined by Brown (1995), as cited by Rogers and Pilgrim (2010). Echoing social causation to some extent, Brown outlines the flexibility of social constructivist thought in adopting social 'facts' with the aim of this allowance being to facilitate the interrogation of the social forces which enable and promote their existence.

This concession is deemed appropriate in order to practically address social issues: the central focus of this movement and in keeping with a pragmatic research approach employed herein. Further, again in line with aspects of social causation highlighted above, Brown notes the Foucault-inspired trends towards the deconstruction of social phenomenon; a broad and critical examination of the discursive practices and power relations which conspire to produce and reproduce this 'reality' whether in terms of social reality or the production of scientific knowledge (Foucault 1963).

The outlined approaches have at their heart the pragmatic need for critical appraisal of persisting phenomenon related to mental health and illness. This trait is then supplemented by a willingness to critically engage with the dominant or 'real world' conceptions in order to understand how such have emerged and thus influence the future direction of the discourse. These aspects within the sociology of mental health and illness are employed presently in order to explore the stigma towards depression within rural settings by critically examining the socially derived conceptions of the condition, the impact of this upon the proliferation of stigma towards same in this setting, and the influence of each of these aspects upon the potential functioning of the supportive aspect of social networks.

Symbolic Interactionism

"Symbolic interactionism directs our attention to the detail of interpersonal interaction, and how detail is used to make sense of what others say and do" (Giddens 2006, p. 23).

Herman-Kinney and Verschaeve (2003) argue that predictability is a fundamental need of every individual in order for them to adapt appropriately to living in the world around them. An unpredictable environment stunts activity as it requires that a new set of norms and rules must be continually learned and digested before any form of progress can be claimed. Symbolic interactionism explains how predictability and certainty is established and understood across social life, with this frame of enquiry making it the cornerstone of the present study which explores circumstances in which the establishment of these features is suggested as laboured.

Commenting on the work of Mead, Ritzer and Goodman (2004) detail that causal significance within this concept is centred upon social interaction with an acknowledgement of the view that "meaning stems not from solitary mental processes but from interaction" (2004, p. 353). Social meanings and social symbols are, then, while reflected upon and manipulated dependent upon the specifics of each social occasion, essentially learned phenomenon with this acquisition of knowledge inextricably framed by our cultural experiences. Our self-understanding and interactions with those around us are thus formed by our social context and its symbolic mediation.

Discussing the work of Blumer, Sandstrom *et al.* (2010) outline the essential assumptions of symbolic interactionism noting the central premises. Firstly, that in order to understand human behaviour we must be knowledgeable as to how people define things, secondly that this definition is based upon social interaction, and thirdly "that the meaning of the things we encounter are altered through our understanding of these things" (2010, p. 8). These guiding premises are supplemented by several other assumptions which acknowledge the human ability for reflexive thought and its role in determining behaviour, the centrality of symbols as the basis for interaction and the imposition of emotion and meaning upon them, and our complicity in influencing society through partaking in "the social act" (Sandstrom *et al.* 2010).

The role of the symbol is unsurprisingly a key aspect of the interactionist stance. Symbols, being themselves artefacts, hold crucial importance as it is through them that "we create and acquire culture, or the ways of thinking, feeling, and acting that characterize our society" (Sandstrom *et al.* 2010, p. 53). Ascribed meaning, or a variety of meanings, by the society around them, symbols become the primary form through which individuals endeavour to establish a semblance of sense from their ultimately abstract social environment. They offer a frame of reference, a focus upon which one may hang emotions, virtues and feelings; guidance as to the very meaning of our daily experiences. Equipped with a knowledge of the meaning attached to the symbols in our social environment, "we combine and cluster symbols to form concepts that we use to sort our sensory experiences into orderly social categories" (Sandstrom *et al.* 2010, p. 54) for easier access and implementation. Pertinent to the present study, present within language, movement, and conversation, symbols facilitate that transfer of meaning

between individuals and/or institutions thus acting to streamline social interaction and enable the efficient and progressive navigation of the social environment.

Socialization

Interactionists assert that the development of an understanding about how objects and symbols are endowed with particular powers, is dependent upon the detail of one's socialization; "an ongoing, interactive process through which individuals develop identities and learn ways of thinking, acting and feeling that characterise their society" (Sandstrom *et al.* 2010, p. 77). In primary socialization, en route to maturity, the child (on whom great attention is placed) is said to learn two essential aspects of living; an understanding of the ways of thinking which encompass the culture of their social environment, and, as a product of this, a sense of self. In describing the concept of the looking-glass self, Cooley declared that a child learns its own self identity via a three stage process centred upon its interactions with others. In two processes which run simultaneously, the child imagines how he is viewed by others and the judgement they may make upon him, then, based upon their understanding of this judgement, a self-feeling is generated and internalised. Cooley asserted that this process is not confined to one's formative years, but, noting the reflexive self, is instead a continual and evolving process in which one's identity is repeatedly reappraised based upon prevailing social and personal conditions.

The work of Mead elaborated further on this thinking by articulating a notion of how one came to obtain the views of others in the first instance. Again referring to the study of children, Mead suggests that movement through stages of preparation, play, and games allows individuals to learn to think outside of a self centred orientation towards understanding a more collective view – the generalized other. This concept refers to the ability to understand the expectations and normalities of a community in which one is immersed and through which our individual behaviour and our sense of self is fashioned. Notable critiques and developments upon these core ideas include Denzin's contention against the universality of passage through the phases described by Mead instead seeing such development as being a function of the level of interaction to which a child is exposed, and also Shibutani's updating of the generalized other concept in adaptation to modern industrial societies to include a plurality of reference groups to inform one's definition of self (Sandstrom *et al.* 2010, p. 85-87).

An understanding of symbolic interactionism is thus of importance if one wishes to understand how society has arrived upon the marginalisation of a particular cohort as dealt with in the present study. The theory emphasises a common understanding, while also providing a theoretically simple, yet effective suggestion as to how symbols and meanings common to a society are proliferated through a socialisation process fundamental to social development. It is a two-way process consisting of the learning of these social rules followed by sustaining their efficacy through the application of these dictums to the self and others. Through this, one may argue, and pertinent to the present study outcomes, we condition ourselves and others to comply with the expectations of society.

In receipt of a basic and continually updating knowledge of social norms and expectations, one may be considered equipped to navigate efficiently and progressively through the social environment. However, in absorbing this learned culture, one also often unknowingly becomes armed with a set of social and cultural norms and expectations which act to enable the bearer to distinguish those who fall within their social group and those who fall outside. Discussing labelling theory, Becker (1963) outlines the interactionist view of deviance as "the infraction of some agreed-upon rule" (1963, p. 78). Critical of the placing of emphasis upon the deviant person or group who become outed and othered by their supposed committal of a deviant act, Becker instead seeks to return the emphasis upon the origin of these rules; society itself, asserting that "social groups create deviance by making rules whose infraction constitutes deviance" (1963, p. 78). In other words, it is the placing of meaning upon actions, words and other symbols which determine deviance moreso than the quality of the act which is deemed of deviant nature. These rules, then, hold little semblance of stability but are instead, hopefully, open to redress.

Crucially in terms of the present study, one may argue that symbolic interactionism provides the basis for comprehension of the mechanisms by which society members view and ultimately judge others within society. But why is how others view another important?

Self

To answer this, one must delve into the discourse on the self covered in detail within symbolic interactionism and specifically in the work of Goffman (1959). Prior to his classic work on stigma which is discussed below, Goffman developed upon the ideas of Mead putting forward his conception of the self as reliant upon what he termed *I*, that is the individual self, and *me* which he used to refer to the self that exists following adjustment to social constraints. Displaying in nascent form ideas which would be developed in his later work on stigma in which management of self is taken to a higher level, Goffman describes the individual in terms of a theatrical performer whose every action is carefully choreographed in front of the 'audience' comprising those with whom they interact. The actor is compelled by a need shaped by a social expectation, to portray a seamless and appropriate self-image that is appreciated by others in order to gain their acceptance. To counter critique, the individual must perfect the technique of "impression management"; developing strategies to contain or subvert challenges to the performance and its aims from a suspicious or malicious audience. To do this, operating within what Goffman termed the 'front stage', individuals actively hide aspects of their true identity regardless of how common such aspects are to others, with such presentation of a limited self conveniently wrapped up in notions of dignity and privacy where the actual self is deemed unworthy for public display or the prerogative of the individual to guard.

Goffman's work to an extent expands upon the ideas of Cooley (1902/1964, p. 169), as cited by Ritzer and Goodman (2004) which presents the individual as a somewhat unsure, unconfident, appraisal-craving being. In his depiction of 'the looking glass self' Cooley provides an assessment of how individuals come to define themselves through the creation of an image of themselves within their own imagination, and an estimation at least of how this image is understood in another's mind. The combination of these images move to create what Ritzer and Goodman term "some self-feeling" (2004, p. 356) within the individual such as the senses of shame or pride which serve ultimately to instruct one's social behaviour. This work mirrors that on self-esteem. Described as "an active evaluative process towards the self" which comprises "both explicit (conscious and deliberate) and implicit (automatic, non-conscious) components" (Hulme *et al.* 2012, p. 164), the maintenance of self-esteem is of crucial importance in relation to, as a relevant example, both recovery from depression (Brown *et al.* 1990), and also may play a defining role in the onset of the condition also (Sowislo & Orth 2012). Noting primarily the work of

Cooley as discussed above, Sandstrom *et al.* (2010) detail how interactionists note three components which contribute to self-esteem; reflected appraisals, social comparison, and self-efficacy, each of which may be viewed as dependent upon the other. Reflected appraisals highlights the weight which an individual will likely attach to the views of others, or, and it is suggested more importantly highlighting the importance of group-think, their perceptions as to the views held by others in relation to an individual. In this case, the understood views of others, the product of an active process of moulding and remoulding the evaluations others have offered, serves as a template for which an individual conducts a self-appraisal. Social comparison could be seen to be a concomitant element in this process as we judge ourselves against a reference point of individuals or groups with whom we view ourselves to identify. Lastly, self-efficacy, the sense of being in control of one's own actions and destiny, could be suggested as a function of reflected appraisals and social comparison as it is through an active reflection upon both of these aspects that the bounds of our individually determined efficacy is negotiated (Sandstrom *et al.* 2010).

Building on the work of Mead, Goffman and Cooley, Blumer sought to expand upon same in his definition of the self noting that, promoting the weight of human agency, the individual is the constructor of his own reality via the way in which he acts towards himself, which in turn determines how he acts towards others. The person who imagines himself the keeper of his own destiny, a respectable person, or a person of high standing will, it is assumed, portray this confidence in social interactions and thus directs others opinions on how to view him. However, one must be cognisant that, in keeping with the views of symbolic interactionists, the construction of one's own reality is entirely dependent upon the socialisation experienced. This is, moreover, then, dependent upon the social environment in which one resides and the dominant hegemonic principles, values and ideals of this environment. Resolution of this potential conflict between structure and agency is discussed further below.

The Work of Bourdieu

While symbolic interactionism provides an immensely useful platform to understand the production and reproduction of social actions and interactions, it is important the role of individual human agency is not forgotten. In what could be understood as an expansion upon the core themes of symbolic interactionism, the work of Pierre Bourdieu which

centres upon, but is not limited to the notion of habitus, moves to address this concern. Acknowledging the presence of an overarching social structure and its influence in determining the life of the individual as articulated in socialisation, but also giving significant weight to the role of individual agency, Bourdieu sought to reconcile the two to understand how practice is influenced - a central concern of the present study.

The notion of habitus holds many similarities to the interactionist idea of socialisation with Bourdieu describing it as comprising a "structured and structuring structure" (Bourdieu 1994, p. 170, as cited by Maton 2008, p. 51); structured by an understanding of past experiences and circumstances, structuring of future endeavours through this understanding, and a structure itself as it is an ordered process. Maton (2008) provides a useful summary describing habitus as focusing upon "ways of acting, feeling, thinking and being... how we carry our history (and) how we bring this history into our present circumstances" (2008, p. 52) towards making choices which determine our actions. Focusing upon the term 'dispositions', habitus, he feels, describes the internalisation of social facts and bridges the personal and the social as for even though the personal content of one's life experiences may be unique, they are inextricably "shared in terms of their structure with others of the same social class, gender, sexuality, occupation, nationality, region and so forth" (Maton 2008, p. 53).

As an example of the power of culture within a social arena to frame such dispositions, Bourdieu noted the importance of the 'doxa' within a social space. Appearing early in Bourdieu's work, doxa is seen as "a set of fundamental beliefs which do not even need to be asserted in the form of an explicit, self-conscious dogma" (Bourdieu 2000, p. 16, as cited by Deer 2008, p. 120) but are instead asserted in an apparent reflexive vacuum and yet, in spite of the apparent lack of rigour applied to such thought, held to be integral and true. The doxa is the resilient unquestioned, the taken for granted undercurrent of shared belief, and holds immense power as, by virtue of its pervasiveness in both field and habitus, it is ceaselessly reproduced and reinforced. Doxa guides social practices through its symbolic power, embedding itself in institutions and social relations, in doing so further strengthening its position and thus reducing the likelihood of rebellion against it or the questioning of its legitimacy.

While the above reference to structure lends itself to the broad concepts which were the initial target for discussion, Bourdieu states that the structure is not the sole determinant but is one part of a relationship which acts to produce practices. In equation format, as provided by Maton, Bourdieu stated that practice is the product of the relationship between one's habitus (dispositions) together with one's place within the social environment (capital), taken within the current circumstances persisting in this same social environment (field). Bourdieu saw this as an 'obscure relation' as each individual part is itself moulded in some way by another component within the equation. In understanding practice, then, Bourdieu saw habitus as transcending the structure-agency debate. Practice incorporates the identification of the pervasive 'regularities' of a social environment alongside the implementation of the 'practical logic' of the individual based upon, though not entirely under the control of, their social situation and experience as individual freedom and prescribed social order are seen to influence each other.

Within the context of the present study, understanding the interaction of socially embedded symbols is crucial with a central aim of the research being the gaining of an understanding of the symbolic positioning and attribution of depression in particular within rural Ireland. Further to this, the present study seeks to examine the role of this particular symbolism in influencing the degree of social interaction in which community members engage and the perceived limits it places upon one's freedom to portray a truthful depiction of self.

Stigma

Attaching itself in parasitical fashion to a multitude of cohorts and individuals based upon aspects of past (Smith 2013) and present (Mayock *et al.* 2008) lived experience, one may suggest that 'stigma' has become an acceptable byword for oppression within modern society.

According to Biernat and Dovidio (2000), "stigma can be a challenge to one's humanity and is personally, interpersonally and socially costly" (Dinos *et al.* 2004, p.180). Research on the outcomes of stigma suggest it can lead to the imposition of discrimination upon the bearer (Corrigan *et al.* 2003), exclusion from healthcare, civic and social life (Acuña & Bolis 2005, Whitely 2005, Thornicroft 2006), economic marginalization (Mowl & Fuller 2001) and physical segregation (Barke & Fuller 2001), contributing to an erosion of self-

confidence (USDHHS 1999), and a decrease in life satisfaction and psychological wellbeing (Markowitz 1998).

Given the centrality of this concept to the present study, this section aims to briefly discuss the origins and evolution of the concept of stigma together with the mechanisms which facilitate its proliferation.

Origins & Evolution of Stigma

Based within the theoretical perspective of symbolic interactionism, the work of Erving Goffman (1963) remains the seminal manuscript in relation to providing the inspiration for the continued growth in the academic pursuit of a greater understanding of the concept of stigma. Goffman's notes on the "management of spoiled identity" set the agenda for research into the origins, operationalization, and outcomes of the stigmatisation of individuals and groups in society.

Tracing its roots from the associations of moral significance of ancient Greece, Goffman viewed stigma as a phenomenon which espoused "the situation of the individual who is disqualified from full social acceptance" due to their possession of "an attribute that is deeply discrediting" (1963, p. 9,11). Goffman outlines his recognition of the multitude identities which form each individual describing three differing types; the social identity concerning the form of the self which one presents to the outside world, the personal identity as recognised by those acquainted closely with the person, and the ego identity which denotes one's inner feelings about one's self (Leff & Warner 2006). In providing such recognition, Goffman automatically triggers consideration for how the offense of each or all of these aspects may impact upon the individual and their broad identity formation. Goffman also details a simple, almost self-explanatory classification of three differing types of stigma relating to "abominations of the body", "blemishes of individual character" and "tribal stigma(s)", described with the implicit understanding of the legitimacy of the attributes contained within these types as being discreditable by the majority cohort of "normals" whom are inferred to hold hegemonic social status (1963, p. 14).

Uncertainty of social standing is the pervasive and persistent condition for those contained within these groupings as the individual concerned is condemned to an existence whereby

"the sense of not knowing what others present are 'really' thinking about him" (1963, p. 25) flows through the core of every social interaction. Acceptance or social advancement may indeed be achieved, however, they remain continually mired by the doubt that either is genuine. This is due to an expectation or suspicion that the actions associated with each are driven not by the conventions of normal social processes, but are instead perhaps completed as sympathetic gestures aimed at generating appeasement.

Providing an early description of the notion of courtesy stigma which looms large in the present study, Goffman describes the existence of a contagion effect whereby the "problems faced by stigmatized persons spread out in waves" (1963, p. 43) in the direction of close connections within their social networks. This is a transferral of energy and attribution which may result in the termination or avoidance of such relations where possible by those closely acquainted 'normals' for fear of guilt by association within the eyes of wider society.

Acknowledging these potentially devastating impacts upon both their social lives and indeed the lives of those within their close circle of companionship or relation, Goffman suggests that the stigmatized must embark upon a campaign of information control in order to avoid this fate. An exhaustive process of concealment, deception and remedy, such control is demanded upon every aspect of one's being in order to avoid the arousal of suspicions which may compromise the act, a process which ultimately becomes "'fixed' as a part of (his/her) personal identity" (1963, p. 84). Irrespective of the efforts made in this regard, however, Goffman suggests that such a process may in itself become futile. This is due to one of the central characteristics of stigma and of the present study, that of the removal of the power to control such information about one's personal life, becoming prominent through the increased role of those who are termed "biographical others" (1963, p. 85) charged, or indeed who take it upon themselves, to compile and disseminate an account of one's life with special emphasis placed upon one's most socially salient attributes, often attaching the attributes of one's kin also. As part of this process, using the term "cognitive recognition" (1963, p. 86), Goffman refers to the act of 'placing' an individual; the attachment of characteristics or identity markers onto a person by those who know little or nothing about that person otherwise. It is essentially "an act of perception" (1963, p. 87) open to significant abuse and manipulation, a significant tool of social control whose power is contained in its ability to prosper whilst being removed

entirely from any attempt by the stigmatized at managing their social identity, a level of control which may be possible among those known personally.

With reference to Goffman and the later work he inspired, such as the important work of Jones *et al.* (1984), later commentators sought to elaborate upon the mostly person-centred approach to stigma within his work seen to place the emphasis upon the stigmatised individual or the purported source of their stigma without sufficiently questioning why this merited, and is accepted to merit, attention by others. It was felt that the language of Goffman in relation to some aspects of his description lacked a required tone of criticism instead leaning towards the acceptance and legitimisation of the behaviour of those who act upon stigma based stereotypes. While one may argue that the presentation of such a critical piece was perhaps never the author's intention, many commentators nonetheless sought to redress this balance during the somewhat laboured but valuable reconceptualisation phase from what may be seen as the Goffman-inspired mainly descriptive analysis of the way things are encapsulated in the stereotype discourse, towards a concept of stigma which, with a more interrogatory zeal, traces the past and present sources of stigma, its structural and socially constructed nature, and the conditions and components required in order to facilitate its proliferation (Dinos *et al.* 2004).

This movement towards a discussion of the social components needed for the production of exclusionary and discriminatory behaviours is highlighted in the work of Link and Phelan (2001). Offering evidence of the slow transition towards their more component-oriented definition, Link and Phelan outline their view of stigma as when "elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allow components of stigma to unfold" (2001, p. 367). The authors note the interplay between the component of labelling; the imposition of a socially selected salient attribute upon an individual or group, and the act of stereotyping which operate together on a suggested preconscious level to segregate "us", what Goffman may refer to as "normals", from "them" – the suggested menacing, immoral, lazy, and/or deviant. With this process underway and group separation in motion, the way becomes clear for the adoption of a "rationale...constructed for devaluing, rejecting and excluding" (2001, p. 371) the other; key aspects required for status loss and the legitimation of personal and institutional discrimination both towards and within cohorts. The authors conclude with an explicit emphasis upon the necessity of the aforementioned components to converge upon a

power situation as in the view of the authors, ultimately, "stigma is entirely dependent upon social, economic and political power – it takes power to stigmatise" (2001, p. 375). Power is seen as the driving force behind the momentum of each individual component which encompasses their conceptualisation, without this power, they argue, such components acting in unison would hold limited ability to stigmatize.

While the work of Link and Phelan broke significant ground and gained widespread support among commentators, others continue to offer supplementary analysis. Speaking in mainly structural terms, Corrigan and Watson (2002) present a model of stigma encompassing three central components which operate at an individual level; stereotypes (i.e. widely held negative beliefs about a certain cohort), prejudice which is viewed as a hostile emotional reaction to these stereotypes, and, lastly, the manifestation of this prejudice; discrimination. This model was later supplemented by Thornicroft (2006) who, in a call for action upon the issue in relation to mental illness, cites the problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination) as key facilitators to stigmatisation.

Mechanisms Underlying Stigma

Major and O'Brien (2005) provide a useful review detailing four mechanisms by which stigma affects the stigmatized. Commencing with the most readily observable mechanism, that of 'negative treatment and discrimination', the authors suggest that the cyclical nature of such behaviour acts to limit access to economic, political and educational resources. With such barriers in place, they argue, implicated individuals are often denied opportunity to further or enhance their position thus invariably leading to isolation and, with that, occupation of the ranks of lower social status, a state that itself may elicit further negative judgment and actions of discrimination. The importance of perception, as so central within the present study, is the common theme to two such other mechanisms; 'expectancy confirmation processes' and 'automatic stereotype activation-behaviour'. In the former, perception is understood to lead those who perceive stigma in another to behave towards them "in ways that directly affect (their)... thoughts, feelings and behaviours" (2005, p. 396) in doing so altering the targets behaviour towards the ultimate confirmation of the perceivers initial views, however inaccurate. In the latter mechanism, common perceptions held by the stigmatized on the basis of their comprehension of cultural

stereotypes are said to act through ideomotor processes to produce behaviour which assimilates to the stereotype thus producing "stereotype-consistent behaviour" (2005, p. 397).

The final and currently dominant mechanism, identity threat theory, is also based somewhat on perceptions and echoes some of Goffman's central ideas by describing how continual anxiety and uncertainty of social standing is the outcome of a threat to one's identity posed by the "attributional ambiguity" associated with stigma.

Presenting a model of stigma-induced identity threat, Major and O'Brien, referring continuously to the transactional models of stress and coping brought to the fore by Lazarus and Folkman (1984), describe the process by which the outcomes of several stated components come to exert an influence upon the stigmatised individual. The model itself is strongly guided by the ideas of symbolic interactionism with "collective representations", an acknowledgement of the common understanding members of society come to establish through socialization, noted in relation to the dominant culture and their (and their groups) place within this. The presence of collective representations denotes an acknowledgement "that they (stigmatised groups) are devalued in the eyes of others... and recognition that they could be victims of discrimination", but perhaps most importantly in terms of the present study, a fundamental awareness "of cultural stereotypes, even if they do not personally endorse them" (2005, p. 399). Placing culture as the driving force of this model, the other components of situational cues and personal characteristics, comprising sub-components of stigma sensitivity and group and domain identification, can be seen to emanate from this overarching determining factor.

The culmination of these components working in combination, they argue, is the production of an appraisal of a perceived "stigma-relevant stressor"; a potentially damaging force to the integrity of an individual's social identity, which must then impinge upon the coping resources of the individual to elicit suitable responses. Such responses are seldom desirable and include those which are involuntary such as anxiety and increased blood pressure, and also those voluntary responses encompassing the allocation of blame to others and/or society, social disengagement, and/or acceptance of one's socially perceived identity and self-immersion into this constructed group. Often such 'voluntary' responses are far from this but instead are what may be seen as

obligatory responses which the individual may feel powerless to avoid. In either instance, all such responses must be seen to require to some degree a movement away from one's desired normal lived experience (Major & O'Brien 2005).

Comprehension of the evolution of understanding in relation to stigma and courtesy stigma emerge as key in the present study as the rudimentary target centred and componential power focused approaches intertwine. Further, considering the subject matter under consideration presently, cognisance of the potential impacts of stigmatisation upon one's psychosocial wellbeing is crucial.

Social Distance

An important way in which discrimination towards a cohort manifests relates to everyday social interactions which, on the basis of the possession of a stigmatising attribute, an individual may be restricted from partaking or excluded entirely. Related to stigma, social distance is defined as "the amount of distance that individuals of one group would hypothetically place between themselves and the members of another group in certain personal contact situations" (Dietrich *et al.* 2004, p. 349). Acting as a barometer of exclusion, the concept seeks to assess the relative willingness of a person or group to engage in relationships of varying degrees of intensity and intimacy with those who have been labelled as holding a stigmatised identity (Lauber *et al.* 2004, p. 266). A rebuke to traditional geographically centred theories of contact which deemed physical position within space as the foremost determinant of social interaction, though also often employed in conjunction with such theories, the construct of social distance seeks to explore the extent to which the 'degree of sympathetic understanding' between individuals determines the functioning of the social environment.

According to Wark and Galliher (2007), social distance has its conceptual foundations in the work of Georg Simmel in relation to group membership in which he expresses the potential for an individual to be both physically and consciously near, and yet distanced from a group due to the perceived differences or group traits which serve to condition one's response; feelings of relation and separation occupying the same instant.

Under the influence of Simmel's teaching, Robert Park sought to examine salient social issues in post-war America, surveying Japanese-American relations in order to understand (or perhaps expose) how such tensions were impacting upon the social dynamics between differing ethnic groups. As part of this research, Park tasked Emory Bogardus to provide a quantitative indicator of social distance. Bogardus sought to combine aspects of the pioneering social survey work of W. I. Thomas with robust statistical analysis in order to interrogate the social distance between racial groups. The scale developed was thus "the result of a unique convergence of biographical and historical circumstances" with its creator guided by a combination of "his own unique experiences, the discipline of sociology, as well as the larger societal context in which he and his fellow sociologists lived" (Wark & Galliher 2007, p. 393) at the time of its conception.

Crucially in terms of the present study's focus upon rural community and the common conceptions of community relations there, Bogardus saw that irrespective of cohabitation in close proximity within the same spatially-bound community setting, it is the aspects of mutual understanding, emotional intimacy, and social prejudice shared by individuals that will inevitably determine the depth of the relationship they may share. Bogardus (1959), as cited by Ouellette-Kuntz *et al.* (2010), hypothesized that it is the prejudice and discrimination bred from the undermining of one's social status that is accountable for the increase of social distance between individuals. Faced with interaction with an individual perceived as wholly different from oneself, it is argued, the individual seeks to place greater social distance between himself and the other interactant, a movement that decreases in line with the recognition of similarities in personality and status between interactants (Ouellette-Kuntz *et al.* 2010).

Influence of Social Distance upon Social Tie Formation

Inclusion of the concept of social distance and the implementation of a modified version of the aforementioned scale within the present study is based upon the assumption that such distance, or in this instance the social distance respondents perceive others would desire, is an indicator for perceived societal discrimination against those experiencing depression. Further, one may contest this may also then be viewed as indicative of the obstacles facing those experiencing depression in forming neighbourhood ties.

While using a somewhat different 'social characteristic' based definition, Hipp and Perrin (2009) note the body of work in which the considerable preference for homophily in relation to those one forms ties with has been established on a consistent basis. The authors outline three central mechanisms by which social distance in particular may impact upon the formation of ties in the community. Firstly, citing Bourdieu's concept of habitus discussed above, the authors argue that social interaction becomes unlikely due to a lack of common understanding, perhaps due to the incomprehensibility of one or both parties due to regional dialect or language differences for example. Secondly, citing self-categorization theory, the propensity for individuals to place themselves into definitive categories from which they draw reinforcement of their held views and validation of the lifestyle lived is noted along with the resultant creation of an intense and tightly focused social grouping which, in a spiralling fashion, becomes further distant from others as time progresses. Thirdly, this time citing social status theory, the authors argue for an inevitable separation of those who occupy differing status positions providing the example of those who occupy the status of 'married' or 'single' and outlining the typical roles which accompany these status and the demands upon personal resources they entail which act to minimise the opportunity for interaction between each.

While one may argue that the above mechanisms portray individuals as particularly exclusionary in their approach to the satisfaction of their social needs, such commentary does nonetheless provide interesting suggestions as to the manner in which social ties may be formed or lost. Further, one may argue that the somewhat selfish or self-serving image supplied serves to highlight the frequently transient and tenuous linkages which form social networks, and with that the fragility of social ties especially with reference to the strain placed on same by social forces such as that of social stigmatisation as explored in the present study.

Social Support

It is, evolutionary theorists would argue, part of our human condition to be social, a feature of humanity that begins at birth as we arrive into the world "ready to respond to other social beings...(and) prepared to learn and take interest in the social environment" (Gilbert 1995, p. 117). Such theorists would contend that such social skills are vital to the achievement of humanity's biosocial goals which, centring upon the control of resources,

relate predominantly to themes of attachment, affiliation and rank. The attainment of such goals is based within the everyday social interactions which characterise social life. This study employs social support as a conceptual tool to examine social interactions with a view to understanding the potential ability of those experiencing depression to attain such goals.

Origins and Evolution of Social Support

Our participation in society is facilitated through our featuring within social networks, seen by Brugha *et al.* as "a specific set of linkages among a defined set of persons" (1995, p. 3) which operate across differing levels. Our social networks and the characteristics they contain, it is argued, enable the interpretation of the behaviour of those within them. In symbolic interactionist terms, the social networks we participate in are central to our conscious development as we, through the process of socialization in which our social networks form a crucial aspect, imbibe the norms, values and expectations of our social environment.

Influenced to an extent by the work of Durkheim and Mead (Mead 1934, Durkheim 1951), the works of Cassell and Cobb, both published in 1976, provided the impetus for a generation of social support research. Cobb's work provided the definition and leaned heavily upon the meaning garnered from social encounters as a determinant of health, while Cassell, emphasising the biological and medical perspectives, pointed to the protective functions of support with reference to its impacts upon bodily processes linked to health outcomes (Cassell 1976, Cobb 1976).

Cobb details the concept as relating to the existence of "information leading the subject to believe that (s/)he is cared for, loved, esteemed and a member of a network of mutual obligations" (1976, p. 300) and places a particular focus upon the meaning which can be understood from messages obtained through social participation. Cobb saw social support as a constant in individual development, beginning "in utero" and "as life progresses...(being) derived increasingly from other members of the family, peers at work and in the community" (1976, p. 301), in doing so acting to facilitate coping and adaptation to change through moderating the stress inevitable with occasions of adjustment and crisis.

As noted in a review of the concept by Lloyd (1995), commentators, noting the multidimensional nature of both the definition provided and indeed the concept itself, sought to provide greater detail through the deconstruction of the definition placing flesh upon the themes of belonging, satisfaction of needs (emotional and otherwise), esteem and social participation. An influential review by Barrera (1986) rejected the movement towards one global model instead insisting more precise concepts were needed in order to conduct specific research and thus divided the concept into three broad categories of social embeddedness, perceived social support (a focus of this present study), and enacted support. While Lloyd presents these debates as somewhat controversial and troublesome, from a developmental perspective, such debates have invariably enriched the discourse and enabled a realisation of that very multidimensional nature of the concept that each contributor suggested. Further, it is also notable that the essence of the original definition by Cobb featured heavily in the subsequent definitions proposed serving to supplement as opposed to dismiss that which preceded resulting in the classic definition maintaining a commanding position.

The flurry of research prompted by the work of Cassell and Cobb concentrated in varying degrees upon how social support actually operates towards the betterment of individual health and well-being. Bringing clarity to a confused field, an important paper by Cohen and Wills (1985) summarised that researchers to this point had been espousing two central ideas as to the nature of social support; the functional or stress buffering model, and, secondly, the structural or direct effects model.

The original stress buffering model, highlighted initially by Cobb, suggests that adequate levels of social support can act to protect individuals from the deleterious effects of social stressors and stressful life events which may prove pathogenic. Similarly to the commentary on the operationalization of stigma above, citing Lazarus (1966), the authors suggest an understanding of stress wherein one appraises a situation as threatening but is without the appropriate coping mechanisms to sufficiently manage the circumstance thus exposing the individual to discomfort and unease, an outcome which serves to undermine self-esteem. In the stress buffering model, the authors propose a two-way effect for social support; firstly suggesting that the knowledge that support structures exist to adequately deal with the stressor may act to avert a negative stress appraisal (perceived social support), while secondly, in a more interventionist manner, social support may act to

reduce or eliminate the stress reaction by nullifying the impact of a stressor through the elimination of its genesis at source.

Expanding upon the overall definition of social support, many commentators adopting this functional approach sought to establish and clearly articulate the aspects of support which may be understood to be provided to those experiencing varying levels of personal anguish or crisis. According to Barrera (1986) social support can be categorised to include emotional, informational, tangible and belonging aspects. Emotional support refers to what is traditionally seen as the main function of support that is, essentially, a sympathetic ear, someone to disclose to and discuss with issues which may be causing disturbance or stress. Informational support centres upon the provision of information or advice which may influence or avert a course of action which may prove ultimately detrimental to the individual. Tangible support is associated with the provision of material aid in order to alleviate such a need in another, while belonging support refers to the notions of solidarity and cohesion bourn through participation in such assistance-based social interaction.

The second, structural aspect highlights Durkheimian notions of social integration and embeddedness, suggesting that mere involvement with a social network, akin to the belonging aspect as highlighted in Cobb's definition, is in itself sufficient to create a sense of wellbeing primarily via the involvement with "regular positive experiences and a set of stable, socially rewarded roles in the community" (1985, p. 311). In this direct effect model, this stability is deemed by the authors to be of considerable importance with the predictability of life course considered the key to the avoidance of stressful circumstances. Further, lending from the social capital discourse, the authors also note that integration with social networks may facilitate access to expertise which may guide the individual away from potential negative, stress-inducing experiences. This model is then suggested to be linked to health through the weakening of "emotionally induced impacts" of displeasing circumstances upon bodily systems.

House *et al.* (1988), who found difficulties with the legitimacy of studies used to support the buffering hypothesis, gave further weight to this direct effect model as they posited that based upon a review of prospective studies that had come to light, cognisance of the existence of avenues for the provision and receipt of social support is itself beneficial to health. The individual in this instance experiences a sense of continued wellbeing due to

the understanding of the benefits derived from the social cohesion of being integrated into a supportive collective in which access to resources which may increase the likelihood of the avoidance of negative experiences is improved.

Later thinking in relation to structural social support as highlighted in the direct effect model would come to focus upon ideas based within the symbolic interactionist tradition in relation to the roles and ties maintained in society and how our understanding of these ties facilitates the development of our sense of identity. Uchino provides the example of marriage as one of our most intimate social structures and describes how research points to married persons reporting greater levels of life contentment than their single counterparts stating that identity theorists understand this outcome to be related to notions that assuming the role of husband or wife confers a level of satisfaction upon the individual, adding "greater meaning and purpose to life" (2004, p. 11).

While, in the interest of clarity, social support has been presented above as firstly two separate models, and secondly as containing several different components within each model, it is crucial to acknowledge that models and components are not mutually exclusive and must be seen to operate in concert. Lloyd (1995) suggests that the outcome of these models working in unison, together with aspects of individual personality, is that support can operate through providing regular gratifying experiences giving meaning to life by supplementing the efforts already being made by the individual, sometimes in a state of crisis, to determine their life. This enhances an individual's self-esteem and, by legitimising and reinforcing one's sense of control over their situation, assists in coping with change.

Our behaviour and support-seeking efforts are dependent upon social context (Hinde 1992, as cited by Gilbert 1995). According to Albreacht and Adelman, the meaning of social support "does not reside in the messages exchanged but in the perceptual processes of each participant" (1987), as cited by Miller and Berlin Ray (1994, p. 216). While the above models predominantly deal with the provision of support in times of crisis or change, one must understand that social support is about more than a purely functional response to life's difficulty, instead, as within the present study, social support must be viewed in wider terms as encapsulating a broader social "sense of acceptance" (Sarason *et al.* 1990, p. 109). Sarason *et al.* (1990) outline that this inclusive sense is developed

during early childhood during early socialization, and provides indications at an early stage of development to the individual as to whether they are accepted by others and thus the levels of support they can expect to receive in life. Through this, they argue, individuals establish a sense of confidence and understanding in relation to their place socially and discern the likelihood of others establishing mutually beneficial relationships with them. While one may argue against the determinism implied through the emphasis on childhood in this stance, and also point to the potential for gain of, and/or decline in such social acceptance throughout the lifecycle, such a motion does hold significant qualities in relation to understanding the meaning of social support outside of functionality and points towards the need to understand how potential social support is accumulated.

The Accumulation of Social Support

The present study seeks to explore aspects of the everyday lived experience of those experiencing depression in rural Ireland. An understanding of the perceptions relating to the availability and provision of social support is seen as key to this exploration primarily due to the ability of the concept to assist in the articulation of the social exchanges which take place between social actors, but also due to the consideration made of the micro level social exchanges in the reproduction of social realities.

"Everyday encounters... provide background for many special forms of social support that are needed in a crisis" (Barnes & Duck 1994, p. 176). Social support is not merely evident upon its role in influencing the outcome of an event, instead it must be seen as a developmental phenomenon; accumulated over time, subtle in its evolution and display. According to Barnes and Duck (1994), social support is a function of what persists in daily life as it is within such interactions that relationships are forged, one can establish rapport and, with that, evidence to determine the likelihood of others providing assistance in times of need and the suitability of their support in such times. Referring to previous work by Duck (1994) heavily laden with symbolic interactionist overtones, the authors describe the "traffic in symbols" that exists when people in relationships of varying intensity interact. These symbols are often implicit, mostly unknowingly exchanged, and yet hold great importance in relation to informing the participant's views of each other, and where each may stand in relation to the provision of support if required. Such everyday interaction

"creates and constructs a relationship rather than simply transmitting the contents of one brain to another" (Barnes & Duck 1994, p. 179).

With such relationships formed in varying degrees of intensity and intimacy, normal everyday talk itself is also seen to perform six latent supportive functions; information, detection, ventilation, distraction, perpetuation and regulation. Barnes and Duck suggest that, mirroring the evolutionary theory relating to the establishment of rank (Gilbert 1995), everyday verbal exchanges allow for the deciphering of background information about a person's life and "about the degree of similarity in individuals' interpretation of the world" (1994, p. 181), offering clues as to the likely availability of support should it be required. The development of such conversational ties is suggested to hold the key to the detection of underlying stress and strain as growing familiarity with one's daily normal self allows for the identification of behavioural patterns which may indicate discomfort or torment and trigger intervention. Conversation also acts as a pressure release valve as the venting of daily misgivings allows for the efficient processing of such stressors before they become troublesome, provides distraction through conversation thus allowing the enjoyment of respite from the experiencing of continual stressors, contributes to a sense of regularity and predictability through stable social interaction, and provides comfort through the knowledge a non-threatening platform exists for the discussion of daily issues and concerns and, with that, the incremental accumulation of support.

The authors recognise that often the type of supportive functions offered by daily talk as described above may not be sufficient, and that the type of relationship one has with an interactant determines how support is ultimately sought. However, one may contest that in a non-crisis situation, understanding that the above functions are in the very least available to an individual and the feelings of acceptance and normality which could be associated with this, could in itself prove a source of comfort and support.

While the social support literature places emphasis upon close or intimate relationships, further to the work of Barnes and Duck (1994) one must be cognisant of the very many relationship ties individuals may possess and the important role all ties may play. Granovetter's (1973) work articulated this succinctly by arguing for an acknowledgement of the 'strength of weak ties'; the crucial nature of those ties which may not be entirely intimate or well established but which linger within the background of one's social network.

Granovetter, flowing from the work of Epstein (1969) in defining the effective and extended networks, characterises strong and weak ties as a combination of the amount of time, emotional intensity, intimacy and reciprocity which characterise the tie, but crucially moves beyond an approach which dismisses weak ties as insignificant. Quite to the contrary, Granovetter notes the 'bridging' qualities of such ties as they are suggested to form avenues through which indirect contacts may be reached and, with that, "ideas, influences, or information socially distant from ego may reach him" (1973, p. 1371). Weak ties, then, are suggested to be the vehicle through which an individual gains access to the wider world outside of their immediate focus of interest and may offer opportunity for progression, in personal and professional capacities, which may not exist when one remains encapsulated within the hue of one's strong ties. Thus, examination of capacity for the maintenance of weak ties within a wider social network is merited and included within the present study.

Summary and Conclusion

This chapter has sought to outline the key theoretical concepts to be employed in order to explore the stigma in relation to depression in rural Ireland, and its impact upon the provision of social support there. While discussed separately in the interest of clarity, evidently the concepts presented must be seen as related and interlinking as in unison they assist towards a comprehensive explanation of social reality, highlighting the factors of living which define social relationships and thus the broader social environment.

Symbolism lies at the heart of interaction and forms the spine of the present study as defined and presented within the above discussed concepts. From the grounding of symbolic interactionism which provides an explanation of symbol formation, meaning, manipulation and application, the concepts of stigma, social distance and social support may be seen as variants upon this with these four aspects of interactionism operating within these models to produce social reality.

The discussion of stigma has sought to outline the historical, social psychological and, ultimately, cultural basis for the discriminatory practices of those who crucially hold, or have held, the power base within society, as well as those who are or have been influenced by same. Social distance may be seen as an extension of this concept which

places particular emphasis upon some of the key symbols of suggested normal life in attempting to understand the potential tangible outcomes of stigmatising attitudes when placed into action. Social support represents hope with its discussion framed within the at times somewhat feverish optimism of the potential that exists for individual and social development through the dissolution of the components which allow stigma to flourish. At its most optimistic, social support presents a utopic ideal wherein inhabitants of cohesive communities operate towards mutual benefit. In more realistic terms, as characterised in the work of Granovetter, the incremental but relatively substantial gains to be gleaned through a less partitioned social environment are inviting.

From the above discussion, one may assert that central to the proliferation of stigma based discriminatory practices (including social distancing) within society is the continued agreement with, and apparent unquestionability of the dominant, or indeed the dominating culture, or doxa in Bourdieuian terms, within a society or sub-section of same (e.g. rural society/culture) over time. Addressing this culturally ingrained and supported degree of inertia, this lingering intent, which has apparently remained sheltered from the winds of change driven by scientific and social progress, represents the single greatest challenge to societal development across a range of epoch defining issues of inequality.

The present study aims to employ the above discussed theoretical concepts to address this lacking critical faculty via the exploration of stigma-based discrimination towards depression in rural Ireland. Presented hereafter is a critical review of the literature relating to these foundational theoretical concepts with particular reference firstly to the broad discourse of mental illness, and then to depression in particular.

Chapter Three - Literature Review

Introduction

> "Public attitudes matter. They fuel "the myth that mental illness is lifelong, hopeless, and deserving of revulsion" (Hinshaw 2006, p. xiv)... set the context in which individuals in the community respond to the onset of mental health problems, clinicians respond to individuals who come for treatment, and public policy is crafted. Attitudes can translate directly into fear or understanding, rejection or acceptance, delayed service use or delayed medical attention" (Pescosolido *et al.* 2010, p. 1324).

The purpose of this chapter is to critically discuss the literature in relation to the stigma towards depression, and to discuss the impact of social support upon those experiencing the condition. To provide context, this chapter begins by examining the literature describing the broader stigma towards mental illness with, then, a movement towards the discussion of the concept relating to depression in particular. Both discussions seek to understand the origins of this stigma, while paying particular attention to its impacts upon affected individuals and others in the community. Perceptions of the stigmatisation of those experiencing wider mental illness and depression and the outcomes of this are also discussed. Emphasis is also placed upon uncovering the impact of such stigma upon one's close family or immediate social network, together with a discussion in relation to repercussions among rural populations and the work conducted which examines such stigma in Ireland. The chapter then moves to discuss the literature which details the concomitant social distance which relates to mental illness and depression with this aspect followed by a discussion of the literature in relation to social support and its impacts upon wider mental illness and, then, specifically, depression.

While important global literature forms the bulk of the reviewed material, in keeping with the overall study aims and objectives, special mention is also made of literature which relates directly to Ireland and to rural Ireland in particular where available and appropriate.

Stigma towards Mental Illness

According to West *et al.* (2011), "stigmatizing attitudes towards mental illness include beliefs that people with mental illness are dangerous, cannot recover, or cannot contribute

to society" (2011, p. 54). The presence of a stigma has been described by the World Health Organisation (WHO) as "the single most important barrier" (Datta & Frewen 2010a) facing those with mental illness and may have a substantial impact upon an individuals' capacity to obtain social support and social capital (Whitely 2005). It is a global social and public health issue as there exists "no known country, society or culture in which people with mental diagnoses are considered to have the same value and to be as acceptable as people who do not" (Rose *et al.* 2012, p. 4). According to Jamison, one would encounter difficulty in surpassing overstatement in describing the level of stigmatisation encountered by those who experience mental illness for "it is pervasive in society, rampant in the media, and common within the medical profession" (1998, p. 1053).

But why has this widespread devaluation of those who experience mental illness emerged and what is facilitating its persistence presently? Given that stigma in relation to mental illness has been shown to have adverse impacts upon the psychological well-being and life satisfaction of those with mental illness with potentially grave consequences (Markowitz 1998, Rüsch *et al.* 2009b), a full investigation of this phenomenon is merited.

One may trace references to the stigmatisation of mental illness to biblical times where mention of mental ill health being inflicted by a vengeful deity upon those who had indulged in an array of sinful activity is suggested to provide some of the earliest evidence of the imprinting of associations between mental illness and "moral failings, religious corruption, or a threat to social cohesion" (Thornicroft 2006, p. 171) upon a collective social psyche. Cognisant of this, Hinshaw and Stier (2008) bed their analysis within the suggestion that "the predominant perspective on mentally disordered behaviour has undoubtedly been demonologic in nature, whereby deviant patterns of behaviour and emotion are attributed to possession by evil spirits, animal spirits, or the devil" (2008, p. 371). The consequence of this, then, is the emergence, dominance, decline, but yet residual remainder of notions which place mental illness as a consequence of the manifestation of malevolent spirits. Examples of this within the Irish context are noted in the work of Robins (1986) and also in Kelleher's work on suicide (1996) in which the considerable weight of folklore is seen to assist in the substantiation of such erroneous claims.

Upon this foundation, one may argue in unison with Hinshaw and Stier (2008) that mental illness has become a victim of the endeavour for knowledge whose zeal for learning was not matched by a commitment to reason and rationality. Supplemented by ignorance, and typically, blind faith in, and loyalty to religious institutions as holders of truth, the outcome is noted as the encouragement of "harsh moral judgement and extreme castigation" (Hinshaw & Stier 2008, p. 371) upon those experiencing mental illness by populations of devotees above other values of care and compassion. As disturbing that such a contention may seem, one may argue that it is nonetheless unsurprising upon consideration that many of the numerous religions which contribute to the formation of collective thinking actively promoted, and indeed continue to promote the invocation of supernatural ideals. This was and is done typically in order to explain phenomenon which are, or were, seen as difficult to control, and/or those which posed, or were perceived to pose, a threat to the normal order of things.

Taking the application of logic and reason through science as the contrary to this reliance upon supernatural thought, this immensely powerful and equally dominant institution has proffered some similarly destructive perspectives on mental illness when the more scientifically embedded paradigms have shared periods of prominence. Indeed the early and relatively more rational scientific approaches, while a significant movement away from the hegemony of the supernatural, did little to improve the status of mental illness due to its placement of emphasis upon the body, and thus again the individual, as the source of the malady. The work of Empedocles and Hippocrates in ancient Greece for example, placed emphasis upon various humors deemed to be residing in imbalance in the body as being the cause of mental disturbance, teaching which frequently resulted in gruesome efforts to purge the body of the source of its disruption. Plato and Galen also spoke of humoral excesses as the source of such complaints (Thornicroft 2006, Mathews 2010). Hinshaw and Stier note that both explanations, together with the later biomedical models which rose to prominence, share "a sense of chronicity and hopelessness regarding mental disturbance" (2008, p. 371).

As neither of these lines of thought held a monopoly at any one time, one may contend that each in isolation, but also working in a perhaps unintended combination, produced a hybrid outcome where the residual, often least desirable aspects of each was consumed and digested towards forming part of an accepted truth across wider society.

Rationalisation of Mental Illness Stigma

Such early explanations of mental illness, and the clues as to the dynamics of the social environments from which they emanated, serve as useful footnotes when seeking to compile an image as to why mental illness attracts stigmatisation in the face of ever increasing knowledge and its wider dissemination. In their comprehensive social psychological review entitled *'Stigma as related to mental disorders'*, Hinshaw and Stier (2008) seek to uncover the origins of the stigma of mental illness. Citing the seminal works of Goffman (1963) and Allport (1954), the authors first acknowledge the social-cognitive processes which act to attach an individual to their suitable in-group with aspects such as irregular behaviour serving as a marker to denote one's membership of the contrasting out-group, i.e. the group to which that individual, based on his experiences of family or neighbourhood which serve to condition his sense of 'normality', does not associate. Further to this, citing Stangor and Crandall (2000) and, interestingly, the terror management theory of Pyszczynski *et al.* (2005), the authors suggest this process of othering is then supplemented by, in somewhat deterministic tone, acknowledgement that variation from what is considered normal conduct towards either end of the behavioural spectrum of elation or despair is seen to "disrupt perceptions that one is always in control of one's mind and behaviours" (2008, p. 373).

Recalling the work of evolutionary psychologists Kurzban and Leary (2001), the authors outline how the dynamics of social exclusion have evolved over time in order to afford 'survival advantage' to those who maximise social contact yet minimise exposure to potentially deleterious exploitation or disease. They argue for the presence of internal programs which act to trigger avoidance of those who pose a risk of contagion, dislike for those who offer low opportunity for social capital exchange, and hatred for those outside of one's own ethnic or racial grouping. While the latter aspect may not apply directly in this instance, one may in the least accept the likelihood that the preceding two programs may be observed operating even at a subconscious level in society in relation to mental illness. The intrigue, discomfort and fear engendered by such behavioural digression may be seen to trigger the arousal of stigmatizing responses as a form of defensive mechanism, or, indeed, as a form of capitulation for the breaking of norms of reciprocity upon which the continuation of social life rests by those who reside outside of one's own in-group.

Supplementing this analysis via the adoption of a structural frame of analysis, evoking the work of Link and Phelan in relation to power discussed above, the authors state that "stigma occurs only when a group with social power denigrates a less powerful group, a situation that clearly pertains to individuals with mental illness" (2008, p. 374). Structures of domination exist and, they argue, use resources at their disposal such as stigmatization in order to maintain their dominant position. The authors' note how the stigmatisation of this particular out-group has been continually facilitated by the understood lack of any tangible repercussion in response to such actions as this group is seen historically to occupy an almost subservient position in society and is thus retained in a cyclical situation of holding little power to resist or counteract such trends.

In summary, one may argue that a true explanation for the proliferation of the stigma towards mental illness most likely lies within a consideration of each of the above suggested factors towards the 'rationalisation' of such stigma, in combination with an acknowledgement of the influence of the foundational and continued cultural considerations of mental illness as established within the early thinking of the dominant institutions of both religious and scientific enquiry. Each working independently to declare and assert their version of fact, the demonologic and naturalistic schools of thought were also, and to a great extent remain in confrontation with each other with the perhaps unintended outcome of their very public and unresolved disagreement being the perpetuation of uncertainty and confusion in this regard among the wider population who look to each as the holders of truth. Such confusion may then be seen to manifest through the maintenance of the distorted remnants of each original argument which hold a lingering presence among this bewilderment.

The Operationalization of Mental Illness Stigma

Citing the work of Corrigan and Watson (2002) and the later work of Thornicroft (2006), MacGabhann *et al.* (2010) offer their endorsement of the tri-partite approach suggested in broadly similar terms by both in order to articulate the response of those in society to those who bare a stigma. These approaches, though differing in articulation, crystallise around the three elements which they suggest encompass stigmatisation; stereotyping, prejudice and discrimination.

Adopting the definition provided by Major and O'Brien (2005), the authors see stereotyping as the widely held negative perceptions of others within a culture or society which form the basis for the exclusion, avoidance and/or persecution of the stereotyped group, and highlight how this practice in relation to mental illness has been identified and documented within the literature. Their review yields a collection of negative stereotyping of those with mental illness including the questioning of the temperament, stability, reliability, and self-control of those experiencing mental health problems, while also, and pertinently to the present study, moving to the extremes of querying whether someone with a mental illness posed a physical or emotional threat to others. The authors note that the presence of such stereotypes is instrumental in the development of a 'them' and 'us' mentality within society which, they argue, provides the basis and the legitimacy for "negative affective responses in people's attitudes towards those who they perceive as different" (Mac Gabhann *et al.* 2010, p. 9).

Such negative affective responses take the form of prejudice according to the authors who quote Allport's (1954) definition describing it as an "aversive or hostile attitude towards a person who belongs to a group, simply because he belongs to that group, and is therefore presumed to have the objectionable qualities ascribed to that group" (Mac Gabhann *et al.* 2010, p. 9). Interestingly, the authors rely heavily upon the research conducted in relation to social distance (discussed in greater detail later) carried out by Corrigan *et al.* (2001) and Angermeyer and Matschinger (2005) among others who detail the varying levels of reservation those within their samples expressed towards the hypothetical engagement in relationships of varying intensity and intimacy with those with mental illness. The conclusions drawn from this research suggest the prevalence of a perception, almost across the board, that such individuals were perceived to present a threat and thus propositions of interaction merited careful consideration. Increasing the level of concern, the authors also note more recent general population research from Britain which suggests growth in the pervasiveness of prejudiced attitudes in society based upon responses to a variety of indicators devised to extrapolate attitudes in relation to matters of basic equality for those with mental illness. Referring to research on this matter emerging from Ireland, the authors note that any such work of import conducted by state and national bodies over the previous decade or more suggests that some level of stigma in relation to mental illness exists. Some of this work depicts high levels of prejudicial attitudes in relation to,

for example, aspects of employment and civil rights together with inferences suggestive of the realisation of prejudiced attitudes among others in society in relation to same.

One may argue that the evolutionary and even inevitable outcome of the existence and pervasiveness of such prejudiced attitudes is for the sentiments within same to begin to express themselves in more tangible formats. However, the authors in this instance are more cautious and while suggesting the link, are also tentative, based upon their consideration of the work of Fiske (2000), in putting forward contentions of a direct linkage between attitude and outcome. Mindful of this caveat and noting its value, the authors move to discuss discrimination towards mental illness; the actual experience of unfair treatment which arises as an outcome of a behavioural response to prejudicial attitudes. Noting the substantial works of Sayce (2000) and Thornicroft (2006), the authors outline that evidence exists to assert the proliferation of discrimination due to mental illness "across multiple domains including family and parenting rights, friendship and intimate relationships, social life, employment, housing, immigration, insurance, health and social care, the media and the justice system" (Mac Gabhann *et al.* 2010, p. 12).

In order to further substantiate the above claims of discrimination, research in direct relation to this topic will next be discussed.

Stigma towards Mental Illness: Recent Research

In attempting to further the understanding of the impact of stigma on those with mental illness, Corrigan and Watson (2002) outline how those with such conditions remain "doubly challenged"; firstly in relation to dealing with the often debilitating symptoms of the condition they experience, and then secondly by "the stereotypes and prejudice that result from misconceptions about mental illness" (2002, p. 16). While some commentators suggest that more recent surveys have yielded evidence of participants erring upon the side of providing socially desirable answers, and that different forms of mental illness receive varying levels of stigmatisation, nonetheless evidence of the significant stigmatization of mental illness in general persists. Examples and critical reviews of same are presented below.

A qualitative study conducted by Dinos *et al.* (2004) found stigma to be "a significant concern to most, but not all, participants" (2004, p. 180) with 41 out of 46 London-based participants, each of whom had received various psychiatric diagnoses, reporting feelings of stigma in relation to their mental illness. The authors note fear in relation to their mental illness becoming common knowledge within their social networks, while also detailing incidences of overt discrimination encompassing a range of emotional and physical violence such as, for example, one participants experience in which "the whole street – they set dogs on me... and the children would come and spit on me" (2004, p. 178).

Further discouragingly, according to a systematic review of twenty-two studies discussing barriers and facilitators to mental health help-seeking in young people conducted by Gulliver *et al.* (2010), stigma and concomitant embarrassment emerge as the most prominent barriers to the taking of such action. Importantly in relation to the impetus behind the present study, the authors of this review note that of the articles they examined which held a rural focus, stigma was especially significant, a significance amplified when held in comparison to those considering urban areas.

Inspired by a review article published by Bhugra (1989), Angermeyer and Dietrich (2006) sought to provide a comprehensive updated review of population studies in relation to public beliefs about and attitudes towards persons experiencing mental illness published between 1990 and 2004. A total of 62 studies conducted at national and regional level were reviewed. The authors summarised that the majority of the public view those with mental illness as dependent upon others and unpredictable in their behaviour, while, though mentioned less frequently, overtones in relation to violent or dangerous dispositions were also present. These outcomes are noted to be dependent upon a number of factors with, for example, the specific condition being discussed proving particularly salient. The authors note that a review of the factors of gender, age, and rural or urban habitation failed to produce definitive associations with holding a particular view; however, unsurprisingly higher levels of education and familiarity with mental illness were associated with more liberal and positive attitudes towards mental illness. In spite of the views articulated above, the authors stress that the majority of the public display "pro-social reactions, i.e. they feel sorry for persons with mental illness and they also feel the need to help them" (2006, p. 170). This situation can be interpreted both positively, in terms of inferring a degree of empathy and an openness to engagement, and also

negatively as such a stance places those with mental illness firmly within the role of the dependent other.

MacGabhann *et al.* (2010) in their large study documenting the experiences of discrimination by people with mental health problems in Ireland, provide a recent and comprehensive review of the literature relating to the impact of stigma in relation to mental health. Noting the heavy featuring of studies which rely upon self-reported data and the issues of verification and substantiation this presents, the authors provide examples of research conducted in several countries which depict varying, but substantial overall levels of discrimination experienced by those with mental illnesses. Within a UK study conducted by Read and Baker (1996), almost half of the 778 respondents reported being attacked or harassed in public due to their mental health status while substantial proportions of the sample also reported experiencing unfair treatment in relation to their health care, in employment, and in relation to their roles as parents. In a systematic study based in the USA by Corrigan *et al.* (2003) which recruited 1,824 people from community mental health centres, of the half of the sample who detailed experiencing discrimination for any reason (including due to race, ethnicity, sexuality etc.), 73% stated that their experiences were due in part to their mental illness. Of this cohort, over half recalled experiencing discrimination in relation to employment, while one-third had similar experiences in relation to housing. From a study conducted in New Zealand by Peterson *et al.* (2007) which included 785 people who had identified themselves as having experienced mental health problems, 59% of respondents described experiencing rejection by family and friends and between one quarter and one fifth of respondents reported discrimination emanating from government agencies, banks and insurance companies, and educational establishments.

Finally, the authors discuss the outcomes of a large and transnational study documented by Thornicroft *et al.* (2009) which encompassed 732 participants who had a mental illness originating from 27 countries in relation to their experience and anticipation of discrimination. Mirroring the abovementioned outcomes, suggesting significant difficulties in terms of the maintenance of social support structures, just under half of the sample (47%) reported discrimination in terms of making and keeping friends while discrimination by family members was experienced by 43% of respondents. Further, it is reported that almost two-thirds of respondents felt inhibited in their social lives due to an expectancy of stigma with this inhibition acting as an impediment to applications for employment and

training. Consequently, 72% of participants stated intentions to conceal their mental illness due to the anticipation of undesirable consequences of disclosure.

A number of studies have confirmed that one's position as a relative or close associate of a person experiencing mental illness can pose difficulties associated with the absorption of some of the stigma being directed towards a target and, thus, exposure to accompanying discriminatory practices (Lefley 1989, Larson & Corrigan 2008).

According to Angermeyer *et al.* (2003), the repercussions of this associative stigma reach beyond the realms of the previously detailed discrimination in relation to social interaction and access to social roles, to include discrimination within "social structures, political decisions, and legal regulations" (2003, p. 596) as the formal structures of the State are seen to be complicit in such discriminatory practices. Participants in this qualitative research also mentioned experiencing courtesy stigma through their awareness of the negative public image of mental illness presented through a media biased towards sensationalism and violence-oriented depictions.

Further to, and perhaps in combination with these outcomes, other qualitative research from Sweden in which the relatives of patients with mental health problems were interviewed found that the majority had experienced stigma by association, and while the extent of their experiences varied, it is noteworthy that almost one fifth of respondents (18%) were so perturbed by their experiences that they moved as far as to wish death upon their ill relative in order to remove this aspect of immense difficulty from their lives. This stigma was greater among those relatives who themselves had mental health problems (Ostman & Kjellin 2002).

Stigma towards Mental Illness in Rural Communities

A degree of ambiguity exists in relation to the level of stigma pertaining to mental illness in rural areas with little work directly exploring the personal and perceived stigma held towards mental illness in rural samples. Citing several relevant works from the 1970s and 1980s, Rost *et al.* (1993) describe how "multiple reports indicate that stigma is a particularly important barrier in rural communities where lack of anonymity increases the probability that someone who seeks professional help will be labelled" (Rost *et al.* 1993, p.

57) while also noting other work in which the influence of rural living upon stigmatisation is described as negligible. Hinting at a theory as to why this ambiguity persists, the authors also suggest that as stigma is a sensitive and heavily loaded topic; especially in rural areas there has been an increase in "the social pressure subjects felt to report positive attitudes about mental health" (Rost, Smith et al. 1993, p. 58).

Including an assessment of urban and small town opinions among their qualitative objectives, Angermeyer *et al.* (2004) interviewed 210 patients experiencing schizophrenia or depressive episodes using a self-administered questionnaire shaped by the results of an earlier focus group. Mindful of a potential limitation of this study in relation to the perhaps heightened sense of stigma among this particular sample, one of the major findings reported is that the anticipation of stigmatization by participants was more frequent than actual experiences, with this anticipation evident particularly in relation to access to social roles. Interestingly, those in less urban areas were found to have higher levels of such anticipation than their city-based counterparts in spite of the finding that no difference existed in the actual experience between locations with the authors suggesting that this may be due to the increased social control associated with rural communities.

Considering the discourse in relation to help-seeking behaviours in rural areas as an indirect source of information in relation to the desired topic, Hoyt *et al.* (1997) sampled 1,487 adults recruited as part of a state-wide, longitudinal study in which telephone interviews were conducted one year previously. Respondents completed a number of measures including two two-item scales measuring social support and stigma towards mental health services. As predicted, those in rural areas expressed "significantly higher levels of stigma than residents of population centres" (1997, p. 463) with this effect said to be influenced by size of place with those in the most remote rural environments more likely to hold stigmatising views. Stigma towards mental health care was detailed to be strongly related to willingness to seek mental health care in the future with, as predicted, higher levels of stigma associated with lower levels of such willingness. The authors note that "the effects of rural residence on willingness to seek help operate indirectly, via stigmatized attitudes regarding mental health care" (1997, p. 464). While the outcomes of the study are significant, they are also limited by the small scales used to adjudge stigma towards mental health care and the aforementioned supplementary place of stigma within the study.

Cultural factors, as focused upon within the present study, have been suggested to play a significant role in the proliferation of higher levels of stigma towards mental illness in rural areas. Fuller *et al.* (2000) carried out work in rural Australia in which a sample of persons who participate in the provision of mental health services took part in semi-structured interviews. The authors found that cultural impressions of mental illness contrasted significantly with the attitudes said to dominate in rural areas. Mental illness was reported to be conceived as largely severe and untreatable 'insanity' and thus was deemed incompatible with the traditionally stoic and self-reliant definitions of self in rural communities. This stigma-based clash of conceptions is argued to lead to a reluctance to conceive of one's own mental health issues and with that an unwillingness to seek help. These findings were compounded by the work of Judd *et al.* (2006) in their assessment of the importance of what they term 'agrarian values' – a somewhat deterministic set of attributes compiled from previous research which, similarly to the above research, focused upon themes of self-reliance and responsibility, suffering in silence, occupational productiveness, and the importance of family and friend networks as sources of care. Researchers conducted a cross-sectional community survey with a purposive sample of 467 rural Australian residents who each completed a self-report questionnaire assessing current symptomatology, disability, perceived stigma, self-efficacy and attitudes towards psychological problems. The authors found that help-seeking over one's lifetime in relation to psychological problems was positively associated with lower levels of stoicism and self-efficacy as the stigmatisation associated with mental illness was seen to be less influential upon those who identified less with the values suggested. While the impact of the study is somewhat limited by the sampling method employed and also the lack of young respondents, it nonetheless points to the significant role of local and rural culture in determining the absorption of stigmatisation.

Perceived Stigma towards Mental Illness

Citing several works from the past two decades, Ajrouch *et al.* (2010) outline that "stress in the form of perceived discrimination has emerged as a critical element to the understanding of health disparities" (2010, p. 417). Perceived stigma (also known as public stigma) refers to "the extent to which an individual perceives the public to stereotype and discriminate against a stigmatized group" (Golberstein *et al.* 2008, p. 392). It is a self-rated and subjective concept and is thus regulated by one's affective and cognitive

responses to the environment, a regulation itself conditioned by this same environment. A chronic stressor intertwined with the negative outcomes of stigma, perceived stigma in relation to mental illness emanating from both the general public and medical profession is noted to be negatively related to help-seeking attitudes and behaviours (Barney, Griffiths, Jorm, & Christensen, 2006; Sirey et al., 2001; Vogel, Wade & Hackler 2007 as cited by Loya *et al.* 2010), thus exerting considerable influence upon the outcomes of mental illness.

Examining data gained from the World Mental Health Surveys (n= 80,737) conducted in sixteen countries, Alonso *et al.* (2008) assessed the prevalence of perceived stigma among persons experiencing mental illness. While the findings may be limited due to being based upon responses to only two items within a broad questionnaire, the presence of perceived stigma in 21.9% of the sample of those classified as having a 'mental disorder' is notable. In general, higher levels of perceived stigma were reported in developing countries. The authors conclude that "mental disorders appear to be a more important correlate of perceived stigma than chronic physical conditions" (2008, p. 310).

In other work carried out by Alonso and different colleagues (Alonso *et al.* 2009) as part of the European Study of the Epidemiology of Mental Disorders project, just less than nine thousand participants from six countries completed an interview survey. Of this sample, 815 participants reported experiencing a mental disorder with significant disability, the latter aspect proving a significant limitation of this study as one's admission of significant disability was a precondition for the administering of the perceived stigma items of the survey. Nonetheless, of this sub-sample, 14.8% reported experiencing perceived stigma with this more frequently reported in those with lower education.

The vista of expected stigma is repeated in qualitative work by Angermeyer *et al.* (2004) conducted in Germany among a sample of persons experiencing depression and schizophrenia half of whom live in urban areas and half in small towns. The authors found that most of the sample expected negative social reactions to their mental illness status. However, and of particular interest to the present study, citing Link's (1989) modified labelling theory, the authors found that this was more related to their view of how persons interact with those with mental illness as developed through the socialization process, than to actual personal experiences of stigmatisation. This result lies contrary to earlier work by

Markowitz (1998) who rooted the cause of anticipated stigma within previous discriminatory experiences. Pertinent to the present study, those living in small towns were found to anticipate stigmatisation more frequently than their urbanite counterparts (Angermeyer *et al.* 2004).

In terms of public factors which shape stress perception, Rusch *et al.* (2009a) noted that perceiving greater levels of stigma in society towards mental illness increases ones likelihood of understanding stigma as harmful. In their own work, which is limited somewhat by its cross-sectional design and lack of detail in relation to participant recruitment methods, eighty-five persons with mental illness attending mental health services in Chicago were asked to complete a questionnaire containing items relating to the cognitive appraisal of stigma related stress and perceived stigma among other items. Study findings partly support the model of Major and O'Brien (2005) as the level of perceived public stigma is deemed a strong predictor of stress appraisal, thus the authors cite this outcome as further evidence for the urgent need to "reduce public stigma (in order) to reliably decrease perceived stigma and its consequence, stigma-related stress" (Rüsch *et al.* 2009a, p. 63). Interestingly, in a second paper from the same study, the authors found that stress was associated with involuntary emotional responses as shame and social anxiety figured strongly for those to whom stigma applied (Rüsch *et al.* 2009b).

From the above studies it appears that a degree of uniformity in outcomes across regions exists in samples of those identified as experiencing mental illness. Upon analysis of literature originating from research employing general community samples, a similar trend presents. Most recently, in a nationwide general population phone survey conducted in Australia, when presented with a descriptive vignette articulating depression and schizophrenia in varying degrees of severity, in each instance over half of respondents predicted that the person described would be open to discrimination by others. Invoking the term 'pluralistic ignorance' from the social psychology literature describing the instance in which people erroneously perceive themselves to hold differing opinions to wider society, the researchers also note that scores for items measuring the perceived stigma held by others in society were much higher than those in which the personally held stigma of the respondent was sought (Reavley & Jorm 2011). This finding is of great significance to the present study. The abovementioned finding supports that of Griffiths *et al.* (2006) who compared data from Australia and Japan including the outcomes of personal and

perceived stigma scales from which it was deduced that the Japanese sample also displayed a considerable discrepancy between personally held stigma and perceptions of the stigma others hold towards the mental illnesses described in the vignettes. Further research in this regard is discussed in the *'Perceived Stigma towards Depression'* section below.

Perceived Stigma towards Mental Illness in Rural Communities

Perceived stigma in relation to mental illness is said to be particularly pronounced among rural populations (Rost *et al.* 1993).

A postal survey conducted in rural Australia by Komiti *et al.* (2006) which obtained an impressive 77.7% response rate (n=300), aimed to explore the existence of certain attitudes towards mental health, understand whether differences in these attitudes existed in relation to gender or town size, and whether these attitudes predict one's tendency to seek help from a GP for psychological problems while controlling for illness and socio-demographic factors. The authors note that perceived stigma among their sample was high with over 70% perceiving that an individual with mental illness would be the subject of gossip in their community, while many people were noted as wary of encountering a person who had been admitted to hospital due to mental illness. Perceived stigma was not found to be associated with the size of the town in which one resides. Other results reinforced ideas of self-reliance and self-responsibility discussed above as an understanding that seeking professional help for psychological distress would be the very last resort arrived upon at the exhaustion of all other personal resources pervades. The limitations of this study include the reliance upon self-reported data and the cross-sectional nature of the study which restricts the analysis which can be conducted.

Work published one year previously by members of the same research team sought to understand the role of perceived stigma in determining help-seeking from GPs in rural areas. Using cluster sampling, Wrigley *et al.* (2005) determined perceived stigma using an adapted 12-item Devaluation and Discrimination scale. A response rate of 28.4% was recorded with 142 responses received. From a maximum score of 64 denoting very high stigma, the mean score of the Perceived Stigma Scale was 37.51 +/- 4.93 (Cronbach's alpha: 0.80). While this mean score is relatively encouraging, the authors note that of

those who had felt the need to seek help for mental health issues at some time but did not, embarrassment as lodged within the perception of stigma, was the most cited reason for their inaction. Further, complimenting previous studies, the authors note that higher perceived stigma is associated with more negative attitudes to help-seeking. Together with a poor response rate, the unusual definition of rural applied in this study is also a potential limitation as the study took place in a town with a population of ten thousand residents.

Ultimately, one may suggest that ambiguity persists due to the limited number of studies conducted specifically considering rural stigma towards mental illness with factors such as the social sensitivity of the issue together with the difficulty in terms of the financial, time and travel requirements in order to obtain a rural sample possible explanations for this apparent impasse. The present study aimed to address this shortfall in an innovative manner while also contributing to the discourse on rural mental health stigma.

Stigma towards Mental Illness in Ireland

One may argue that the stigma in relation to mental illness which remains in Ireland (Cunningham *et al.* 2007) is reflected within the Irish academic realm via the "paucity of high quality research" covering this topic (Keogh 2005, p. 8). Even within the landmark 2006 policy document *'A Vision for Change'* which was to outline the future of mental health care in Ireland, a large amount of the evidence compiled to inform policy is based upon dated material, United Kingdom-based studies unsympathetic to the Irish context, or a mixture of both (for example see Mitchell, 1985, Goldberg & Huxley, 1992, and McCormick et al 1995, as cited by O'Connor 2006). The present study aimed to contribute to addressing this shortfall. Mindful of the limited research conducted, a consideration of relevant existent work is necessary in order to facilitate this goal.

Mirroring, one may suggest, the overall progression of thought in relation to mental illness as discussed in the commentary above, in his work entitled *'Fools and Mad: The History of the Insane in Ireland'* (1986) Robbins notes how illness in general was habitually and traditionally placed within the realm of supernatural control. Robins suggests that this thinking was only furthered with the spread of Christianity across the island whose advocates sought to expound upon the deeply entrenched, centuries-old mystical pagan

beliefs. Within an isolated population already accustomed to belief systems and indoctrinated with beliefs about the presence of supernatural determinants of health and illness, Robins argues that one can easily see how earlier societies, with the assistance of structured religious doctrine, made the small leap to use moral corruption and a God's retaliation for this in order to explain the rather strange and often disturbing behaviour of the mentally ill.

The degree to which mental illness is presented in a negative light in early thinking, both medical and otherwise, can be seen to have influenced wider public and institutional opinion in relation to mental illness over the generations. In seventeenth century Ireland, Robins suggests that dominant medical opinion rooted in such thought provided a basis of legitimation for the policies enforced by the occupying British as, in order to protect the sanctity of order and conformity, those with mental illness (described as 'lunatics' at the time) were incarcerated along with others deemed to be socially deviant. Prior to this under the Gaelic Brehon laws, while those deemed insane were sometimes used as sources of amusement, Robins argues they were also afforded some degree of legal rights in terms of land holdings, while their care was viewed as the responsibility of the family or tribe. Once detained, captives became subject to "a deliberate regimen of terrorisation" (1986, p. 24) including regular episodes of starvation, torture and the 'treatment' of blood-letting. The culmination of the normalisation of such practices for the treatment of those deemed insane could be seen to be the instilment of a cultural understanding that those with a mental illness posed a threat sufficient enough to warrant removal from the community, while also that they possessed a trait or attribute of deviance or wickedness which, in line with more criminal elements, required harsh treatment in order to rectify.

More recently, three studies have pointed to concerning levels of stigma in relation to mental illness in Ireland. In a study conducted by the Health Service Executive in which 1000 interviews were conducted in the homes of participants across 62 sampling points around the country, while 85% acknowledged that anyone could experience a mental illness, six in ten would not want others knowing about their illness, while the same proportion expressed a view that those experiencing such illness should not do important jobs (Chambers 2007). Later, based upon their critical review of recent international research discussed above, MacGabhann *et al.*'s (2010) own research took place in Ireland and involved the structured interviewing of 306 recruited participants who had or were

experiencing mental health problems. In a substantial outcome, which the authors suggest amounts to a situation in which "a picture unfolds whereby a person (experiencing mental illness) could potentially feel unfairly treated by their entire social network relating to all of their social interactions" (2010, p. 73), it was found that 95% of those who took part in the research reported reception of some level of unfair treatment due to their experience of a mental health problem. The highest incidences of self-reported unfair treatment arose in relation to making or keeping friends (64%), being shunned by people who knew that the respondent had a mental illness (63%), unfair treatment by family members (61%), and unfair treatment by mental health staff (58%). Other significant findings of unfair treatment related to the undermining or questioning of one's role as a parent (46%) and in relation to finding and maintaining employment (36% and 43% respectively). Perhaps based upon such experiences, the anticipation of unfair treatment by participants was also noted as substantial as 86.2% of those involved described experiencing feelings of distress due to their anticipation of being the recipient of discrimination due to their mental illness with a significant proportion of participants (70%) acting upon such concerns and engaging in the active concealment of this aspect of their identity. Further, many chose to remove themselves from aspects of social life including employment, education and close personal relationships.

As with the previous studies mentioned in their review, the authors reliance upon self-reported experiences, while admirable in terms of inclusivity and desirable from their philosophical approach which lamented the lack of meaningful engagement with those living daily with the social consequences of mental illness, may raise concerns of corroboration and the reliability of data. Similarly, the structured nature of the interviews conducted may have limited the degree of enquiry possible. However, equally, one may argue that the potential difficulties are dwarfed by the outcomes in which members of a marginalised group are afforded the opportunity to detail aspects of the social conditions in which they reside – voices and stories largely unheard in Irish society to this point.

Third and most recently, the National Disability Authority (2011) conducted research among a representative sample of 1,039 adults and a booster sample of 256 people with disabilities examining attitudes in relation to disability in Ireland including mental health difficulty among items considered. Using face-to-face interviews in the homes of respondents, it was found that 61% of respondents felt that those with mental health

difficulties were unable to participate fully in life, almost one quarter would object to their child being educated in the same class as a child with such difficulties, while only 37% of respondents supported the suggestion of adults with mental health difficulties having children if they so wished.

Focus will next centre upon the stigma in relation to depression.

Stigma towards Depression

Understanding the stigma associated with the experience of depression is a central focus of the present study. According to a review of research conducted by Peluso and Blay (2009), persons with depression "face a substantial amount of stigma and discrimination" (2009, p. 201). As a result, the stigma of experiencing depression is noted as being a significant concern in the lives of those affected (McNair *et al.* 2002). Thus, as the following review of literature will detail, experiencing depression has been found to be associated with the imposition of stereotypes, prejudice and discrimination.

In a most recent work by Lasalvia *et al.* (2013) in which 1,082 persons experiencing depression were surveyed in 39 sites across 35 countries, the authors found that 79% of participants reported the experiencing of discrimination within at least one life domain. Though limited by the cross-sectional design, the authors also found such experiences of discrimination led to lower willingness to disclose their depression and a greater propensity towards concealment. These findings support those from earlier work in this area considered below.

Reporting a thematic review of qualitative data from 21 community meetings attended by 1,529 people (911 of which had completed evaluations) and 9 focus groups (n=69) in Australia, McNair *et al.* (2002) detail that the most significant theme emerging from the discussions held within these forums was the stigma faced by those who had been affected by depression. While noting the limitation of the lack of representative sample recruitment, the authors outline that this stigma was referenced as being a considerable determinant of an individual's experience both within the healthcare system and also within wider society. Further discrimination in the workplace and a lack of acceptance of the condition by family and friends is also noted, a finding to which they express surprise

noting the previously considered exclusivity of such stigma to more severe forms of mental illness.

These findings are given some further verification by a later cross-cultural study by Griffiths *et al.* (2006) which yielded data upon stigma levels in Australia and Japan. This study was comprised of a sample of 2,000 adults from 25 regional sites in Japan together with a national Australian sample of 3,998 adults. Using an interview questionnaire, which may perhaps raise questions in terms of the offering of desirable responses, respondents in both samples were asked to articulate their personal attitudes and their perception of the attitudes of others in relation to depression and three other conditions presented in vignettes upon a Likert scale. In relation to personal stigma, while in general the attitudes of the Australian sample were less stigmatizing than their Japanese counterparts, a considerable number (42.2%) voiced concern in relation to the unpredictability of a person with depression. Further, and adding weight to the claims made by McNair *et al.* above, one-quarter of the Australian sample did not accept that a person with depression could not merely 'snap out of it', while one-fifth would decline from employing someone with depression. Comment on the perceived stigma data from this study is presented below.

Of the Japanese sample within this study which, as mentioned, yielded generally more stigmatising views, a trend towards the dismissal of depression is evident with between 40-50% of respondents insisting that depression is not a real medical illness but is instead a personal weakness which one could snap out of if they so wished.

In a somewhat small but recent study considering the views of those with experience of living with depression, Barney *et al.* (2009) attempted to qualitatively examine focus group data (n=23) in Canberra, Australia. The authors detail that many participants spoke of concealing their depression in order to avoid the reception of negative social responses, that they perceived others as being unsure as to whether they were suffering from an illness or were experiencing a sad or low mood, and that the majority of respondents felt that others underestimated the difficulty posed by depression in their lives. Participants also intimated that others placed the blame for their depression on the individual experiencing it, that others perceived them as a threat, while many reported that others did not want to be in the company of depressed people socially. Further to the note on concealability, and most likely based upon the subsequently discussed factors,

participants noted concern about seeking support from both formal and informal sources. Mindful of such outcomes, the authors summarised that "stigma is a substantial concern for people with a personal experience of depression" (2009, p. 6).

Taking a North American example, Cook and Wang (2010) conducted a cross-sectional telephone survey of housed residents of Alberta, Canada using random digit dialling which yielded a sample of 3,074 adults aged 18 to 74 years each of whom were asked questions drawn from a personal stigma questionnaire following presentation of a brief vignette describing a depressed individual. The most significant result of this study found that almost half of the sample (45.9%) indicated that they would view the person described as unpredictable, while just above one-fifth (21.9%) of respondents felt the person described to be dangerous. Citing the work of Rusch *et al.* (2005) in relation to key factors in the stigmatisation of mental illness, as well as the mentioned result on dangerousness, the authors note somewhat redeeming scores of 9.8% and 3.2% respectively for suggestions of avoidance and character weakness. In agreement with previous work by Wang and Lai (2008) the males within the sample were seen to hold more stigmatizing views compared to females, while also those with higher levels of education were less likely to report stigmatising attitudes. No discernable result emerged in relation to age, however, those born outside of Canada were reported to have higher levels of personal stigma with the inference that immigrants from less developed regions transport and maintain the traditional cultural views of depression established in their home country.

These determining factors of gender, education and immigration status mirror almost exactly those yielded by a previous study carried out in Australia by Griffiths *et al.* (2008) which sought to investigate and compare predictors of stigma in which a combined national sample (n = 1,001), local community sample (n = 5,572), and psychologically distressed subset sample (n = 487) were asked questions using a personal stigma scale as part of a wider study. Further to the mirrored determining factors, the authors noted that experiencing greater current psychological distress, having lower prior contact with depression, and holding lower depression literacy were also associated with higher reported levels of personal stigma.

In most recent work, Coppens *et al.* (2013) conducted a representative general population survey (n=4011) across four European countries (Ireland, Hungary, Germany, and

Portugal) assessing attitudes towards depression using personal and perceived Depression Stigma Scales administered to a stratified sample in each country contacted via random digit dialling. In relation to the personal stigma aspect, the authors note total outcomes which suggest a moderate personal stigma towards depression is held as a score of 24 (*SD*= 6.2) from maximum of 45 is recorded. Outcomes of particular note include those in which 48% of respondents personally felt those with depression were unpredictable, that 35% personally felt that one could snap out of depression, and that almost one-third would be inclined not to vote for a politician with depression and view depression as a sign of weakness. The study is limited by its cross-sectional design, a relatively low response rate (31%), a reliance on self-report data, and a lack of investigation into the cultural drivers of stigma. Also, the use of telephone surveys may be seen as potentially allowing for the influence of social desirability bias due to personal one-to-one contact between researcher and participant. Discussion of both the perceived stigma and the Irish elements of this work are presented below. Comparison of the individual country data is presented in the *'Discussion of Findings'* chapter.

Considering the views of youth, in a recently published study Calear, Griffiths and Christensen (2011) aimed to examine levels of stigma towards depression among a sample of 1,375 adolescents aged 12-17 years from rural and urban Australia. Participants were requested to complete the personal and perceived Depression Stigma Scale. Perceived stigma outcomes are discussed later. The authors found that stigmatising attitudes were common among their adolescent sample with a mean score of 14.48 recorded (from a maximum of 36, *SD*= 5.68). In terms of predictors of this personal stigma, the authors note similarity with past research in outlining that such stigma is predicted by being male, younger, and having no personal or parental experience of depression.

In Germany, previous work by Wolkenstein and Meyer (2008) also noted the commonality of such stigmatisation among their sample of 387 persons between 16 and 34 years. The authors found that no improvement had occurred in relation to attitudes towards depression among this young cohort in comparison to previous studies with some evidence, especially from the social distance scale employed, suggesting that if anything some attitudes had disimproved as time had progressed. This is discussed further in the commentary on social distance from depression below.

Evidence to suggest improving personal depression stigma over time does not appear forthcoming. Pescosolido *et al.* (2010) and Angermeyer and Matschinger (2004) detail their studies, based in the United States and Germany respectively, both of which attempt to establish whether there has been an improvement in the attitudes of their similarly drawn samples over a ten-year period. The work conducted in Germany repeated the methodology used in a representative survey from 1990 (n= 2,118) among a similarly obtained sample of 5,025. On both occasions respondents were interviewed using a scale of questions devised to ascertain emotional reactions and desires for social distance. The more recent American study completed a comparison of US General Social Survey data from 1996 and 2006 in which a sample of 676 were given a vignette related to depression and asked questions in relation to stigma seeking to understand perceptions of dangerousness and desires for social distance.

Neither study recorded an improvement in their scores over the ten year periods reviewed. In the German study the authors note a slight cause for optimism as it appears that the prevalence of attitudes which suggest pity and empathy for those with depression slightly improved, however, this is tempered by a correspondingly slight increase in the tendencies of the public to react aggressively to someone with depression. While no improvement is noted in the American study, the authors did note that within the context of their wider study which considered schizophrenia and alcohol dependence, the stigma associated with depression was comparatively low.

Stigma towards Depression in Rural Communities

According to the important work of Griffiths *et al.* (2008), while noting previous Australian work suggesting contrary (BB 2006), remoteness of residence was insignificant in terms of attempting to predict the presence of personal or perceived stigma in relation to depression as "the level of personal and perceived stigma among rural residents is the same as that among their city counterparts" (Griffiths *et al.* 2008). However, one may argue that this finding is far from decisive as a number of studies contradict this stance.

Focusing upon labelling theory, in their research which examined rural-urban differences in the stigma associated with depressive symptoms and the stigma associated with seeking

treatment for depressive disorders, Rost *et al.* (1993) recruited a sample of 200 participants (100 from urban areas and 100 from rural areas) who completed a 14-item scale in response to a depression descriptive vignette. Owing to an unusual recruitment method and the cross-sectional design of the study, the representativeness of this sample is unclear and the impact of this work and the conclusions drawn from it is somewhat limited. However, the results of the study demonstrate that overall urban and rural subjects perceived that people in their communities conferred no negative characteristics upon a person with depressive symptoms. However, exhibiting a degree of miscommunication between these cohorts, rural participants who had indicated that they themselves had previously been depressed expressed that "it is the labelling associated with seeking treatment rather than the labelling associated with the disorder itself that predicts whether rural people with depression have sought professional help" (1993, p. 60). This inference of stigma in rural areas was not repeated in the urban settings. The authors note that the stigma in rural areas is a much stronger deterrent for the seeking of care than in urban areas. This suggested outcome is deemed to be attributable to "the greater flow of information through social networks in rural communities" (Mayhew & Levinger, 1976, as cited by Rost et al., 1993, p. 61) implying a greater likelihood of the absence of anonymity and privacy in rural settings.

Further and more recently, Jones, Cook and Wang (2011), using the same Canadian dataset (n= 3047) and vignette method as the previously mentioned work of Wang and Cook (2010), sought to determine if the levels of stigma towards depression differ between rural and urban populations. The authors found that rural participants recorded higher stigma scores than their urban counterparts; however, they also found that this rural-urban discrepancy was exclusive to the males within their sample even after adjusting for the influence of education, income and case recognition. In explaining the gender specific nature of this outcome, the authors reiterate previously mentioned factors such as the comparatively low experience of depression among males which is suggested to lead to comparatively less knowledge on the issue and thus, they argue, higher stigma.

Citing the recent works of Griffiths (2008), Wolkenstein and Meyer (2008), Peluso and Blay (2009), and Wang and Lai (2008), Calear *et al.* (2011) provide a useful synopsis of the factors which have been suggested to predict personally held stigma in relation to depression together with the outcomes of their own research which had same as an

aspect of their stated aims. While the absolute significance of one's age in this regard remains unclear, it is nonetheless generally suggested that being young, male, having less contact with those with mental health problems, not having personal experiences of depression, obtaining low levels of education, having low depression literacy, and experiencing higher levels of psychological stress predict greater levels of stigma towards depression. Mindful of Thornicroft's (2006) reference to 'the problem of ignorance' in his assessment of the causes of the overall stigma directed towards mental illness, one can see this in application within these factors as the authors suggest that a number of these core factors are explicable by the typically limited experience of young men in particular with depression as females are more likely to experience the condition in their youth and thus may be more informed about the issue, which is suggested to lead to increased tolerance.

Perceived Stigma towards Depression

While the volume of research conducted in direct relation to the perceived stigma attached to depression is limited, what is in existence suggests that careful consideration of this aspect of stigmatisation is warranted.

In their large study in which the data yielded from adult samples in Japan (n= 2,000) and Australia (n=3,998) presented with matching surveys and vignettes were compared, Griffiths *et al.* (2006) found the overall perceived stigma towards depression and schizophrenia to be "substantial" with the proportion of those endorsing the statements outlined in the Perceived Stigma Scale employed varying from 30% to 85% across the combined sample. In relation to depression in particular, two vignettes were used with one depicting major depressive disorder and the second outlining depressive disorder inclusive of suicidal thoughts. With reference to the former vignette, significant proportions of each sample perceived that others in society would hold stigmatising views towards those with depression with 58.9% of the Australian sample and 45.4% of the Japanese sample agreeing to some extent that others believe in a person's ability to snap out of depression at will, while over two-thirds of each sample agreed to some extent that most others would not employ or vote for someone who had depression. The authors recorded no differences in response between the two depression vignettes by the Australian sample and only occasional differences in response by the Japanese sample. Interestingly, those

in the Australian sample were more likely to record a perception that others would hold stigmatising views towards depression. This complex project held a number of limitations including suspicions of cultural differences in relation to the interpretation of questions perhaps distorting the outcomes, the lack of representativeness of the Japanese sample, and suggestions of the influence of social desirability bias in relation to the responses provided which must be considered when assessing the true value of the work.

These outcomes are broadly supported by the recent work of Coppens *et al.* (2013) outlined above who found a strikingly higher degree of perceived stigma than personal stigma with a score of 29 (*SD*= 6.4) from a maximum of 45 recorded. Despite the mentioned limitations, the authors point to the importance of this outcome in terms of understanding this stigma with item outcomes such as 53% believing that most others feel those with depression are unpredictable, the same percentage stating that most others would not tell anyone if they had depression themselves, and 50% suggesting that most others feel one could snap out of their depression, pointing to a perception of low depression literacy across the four European countries included.

Worryingly, research aiming to understand the perceptions of the emerging generation of adolescents in relation to the stigma held by others in society in relation to depression has found similar results. Calear *et al.* (2011) requested a sample of 1,375 Australian adolescents to complete a survey containing a personal and perceived depression stigma scale which held a maximum score of 36. The authors found that reflecting, one may argue, the views of their elders and/or their significant influence upon the younger generation, the adolescent sample conveyed opinions pointing to a higher level of stigma among others in society (*M*=20.53, *SD*=5.06) compared to their personally held views (*M*= 14.48, *SD*=5.28). Again, the ever-present threat of social desirability in response is noted here, however, one may argue that as utilised in the present study, the provision of the option to state one's perceived view of the views of others offers a healthy conduit for one's true views to be expressed as the emphasis becomes placed on the potential failings of others and not one's own personal view.

In one of the few studies from Latin America, employing a structured face-to-face interview method among a sample of 500 residents of Sao Paulo with questions based upon those used in previous studies by Jorm *et al.* (1997) and Angermeyer and Matschigner (2003),

Peluso and Blay (2009) found that most participants expressed a view that an individual with depression "would provoke negative reactions and discrimination in the social environment" (2009, p. 204). Worryingly, again the youth of respondents was statistically associated with perceptions of negative social reactions, while having had personal experience of mental illness was a factor associated with perceptions of discrimination.

In rare work seeking to detail the predictors of perceived stigma towards depression, Griffiths *et al.* (2008) outline that "the findings for perceived stigma consistently differed from that of personal stigma" (2008, p. 6). In this instance, they note that having family experience of depression, having no personal history of depression, lower educational attainment, and higher psychological distress were found to be influential in whether one may perceive stigma towards depression by others with the factors of age and gender proving inconclusive. Supplementing these findings, later work by Calear *et al.* (2011), though limited perhaps to applicability to younger persons due to the sampling implemented, found that holding high levels of personal depression stigma, higher levels of anxiety, being female, and having witnessed a parental experience of depression were all predictors of higher perceived depression stigma.

Stigma towards Depression in Ireland

Though "forty percent of the Republic's population live in villages and rural areas" (Collier 2004, p. 88), despite emerging evidence suggesting a growing problem with depression and suicide in such areas (Riegel 2004, Gray 2005, - 2011, MacConnell & Deegan 2011, O'Brien 2011), there remains a relative paucity of research in relation to stigma pertaining to depression in rural Ireland. Research in this regard is seen to be concentrated at a broader national level. Mindful of this, a review of the available literature in relation to this topic is presented below.

The most relevant work under this topic heading for almost a quarter of a century is entitled '*Public attitudes to depression: A national survey*' (McKeon & Carrick 1991). Conducting face-to-face interviews of a representative sample (n= 1,403) in their own homes across 70 randomly selected areas in the Republic of Ireland, researchers sought to enquire about the attitudes of respondents in relation to depression. Attitudes were determined using a modified version of Cohen and Struening's (1962) questionnaire while

the other desired aspects were ascertained using open-ended pre-coded questions. The findings of the study detailed an all-round more positive view that "somewhat contrary to expectation... the vast majority of interviewees expressed positive attitudes to the depressed" and provided responses which "generally concurred with those currently used in clinical practice" (McKeon & Carrick 1991, p. 119). Such findings include 69% of the sample disagreeing with a statement implying that those experiencing depression 'are only feeling sorry for themselves', while 58% of respondents also disagreed with an intimation that such individuals possess a weak character. Overall, respondents reported a willingness to embrace the opportunity for direct contact with such individuals even in terms of the close relations such as in the role of a child-minder or marriage partner. Results which may be of concern, however, include the almost one-third of respondents who expressed some reservation about employing a person experiencing depression or about such persons caring for children. The authors note that age appears to be a factor in the determination of attitudes with those over 65 years holding a predominantly bleak outlook in terms of the treatment of depression and, reflecting a level of indoctrination within a biomedical school of thought, a near dismissal of approaches to treatment outside of the prescription of medication. In many respects, the above findings are framed by one significant outcome of this study in which two-thirds of respondents did not recognise depression as a mental illness thus, one may suggest, it did not attract the level of stigma anticipated.

Interestingly in terms of the focus of the present study, this work presented a number of outcomes in relation to the opinions of the rural population encompassed within the classifications of 'farmers' and 'rural dwellers'. Farmers were noted as less likely to disagree with the statement suggesting one should avoid marrying someone with depression, more likely to consider the importance of the inherited cause of the condition, and in contrast to those in the 'upper class' and those living in Dublin, were more likely to be undecided as to whether depression was treatable. Significantly, this cohort was also less likely to have had contact with depression. Those classed as 'rural dwellers' appeared to share the view of farmers in relation to the potential familial inheritance of depression and also in terms of ambiguity towards its treatment, while also placing greater faith in the application of drug therapy ahead of counselling. The favouring of inheritance as a cause of depression by both cohorts is suggested by the authors to be due to a greater degree of population stability within their environment as opposed to their urban

counterparts and with that the tendency to hold a greater intimate and multigenerational knowledge of families in the locality.

Aside from the age of the research, conducted in 1989 ahead of publication two years later in an Ireland suggested to be unrecognisable socially to the country of today (Share *et al.* 2007), this study holds significant methodological limitations which may be seen to limit its relevance to modern Irish thinking in this regard. Crucially, the method by which the data was collected, i.e. through face-to-face interviews in the home, may be understood as conducive to the offering of socially desirable answers as participants provided their responses to questioning upon a socially sensitive issue in front of an audience containing the researcher and, perhaps, others within the homestead at the time of interview (Wiseman 1972).

A decade later in a publication taken from a wider project relating to mental health promotion in rural communities across Ireland, Barry *et al.* (2000) conducted a cross-sectional study of the mental health beliefs and attitudes of a rural-based sample (n= 1,014). To understand the attitudes and awareness of this randomly selected quota sample in relation to the issues of depression and suicide in rural communities, a questionnaire was administered by an interviewer. In relation to the findings pertaining to the stigma associated with depression specifically, the authors found a relatively high level of uncertainty as to one's willingness to consult with four suggested professional services upon an experience of depression. This uncertainty was highest among younger persons (those below 40 years) with males more reluctant to consult a GP or psychologist than females. In relation to the social stigma questions, just over one quarter of respondents reported that they would talk openly about someone close to them receiving help for depression, 40% said they would talk to close friends, while 11% said they would keep this hidden. Men were significantly more likely to form part of this latter grouping. Over half of respondents noted that they saw no barriers to them seeking help themselves and of those who did recognise a barrier, only 12% referenced concern in relation to social stigma. Suggesting the influence of youthful pride, or perhaps the threat to employment presented by mental illness disclosure, those with higher levels of education and under 40 years of age were more likely to report barriers to such service utilisation. Questioning in relation to the vignette depicting depression provided a de facto expression of perceived stigma by respondents. From this the authors outline that over one-quarter of respondents

anticipated negative reactions by others in the community to the person with depression with phrases such as 'avoid her like the plague' used to articulate this viewpoint. This work is limited in terms of its relevance to the present topic by its place within a wider study of which stigma towards depression is only a minor element. Further, the use of a recognised depression stigma scale may have provided a more detailed output in relation to this aspect. As with the previously discussed study, concerns also exist in relation to the provision of socially desirable answers by respondents who wish not to appear intolerant or uncompassionate when questioned by a researcher.

In a work published in the final months of the present study by Coppens *et al.* (2013), Ireland is included among a group of four European countries in which a survey of attitudes towards depression was conducted using the Depression Stigma Scales employed presently. A representative sample of 1,000 adults from counties Limerick and Galway took part. Details of the study methodology and potential limitations are presented in the *'Stigma towards Depression'* section above. The authors note that the Irish sample personally held the most favourable attitudes towards depression of the four countries involved (M = 22 and SD= 5.8) with the difference between this outcome and that of the least favourable sample from Hungary (M= 25 and SD= 6.3) significant after controlling for age and years in education. The least tolerant responses of the Irish sample emerged in relation to respondents stating their belief that those with depression are unpredictable (38%), and stating their reluctance to vote for a politician with depression (30.3%). Interestingly, just over one-fifth of Irish respondents stated that if they had depression they would not tell anyone.

The Irish sample also recorded the lowest perceived stigma score (M= 27 and SD= 6.6) with the difference between this sample and the German sample who recorded the highest perceived stigma (M= 31 and SD= 6.4) significant after controlling for age and years in education also. Perceiving that others would not vote for a politician with depression (43.7%) was the highest scoring intolerant viewpoint, while again interestingly in terms of the present study findings, 42.9% of the Irish sample felt that most others would not tell anyone if they had depression. While overall relative to the other countries involved the views of the Irish sample are promising, the limitations of the study, particularly in relation to social desirability bias and lack of consideration of cultural factors driving these outcomes suggests that while this work contributes greatly to a modern picture of

depression stigma and improves upon existing research, work remains to be done to complete the portrait. Further, in relation to the focus of the present study, though Limerick and Galway may be considered predominantly rural counties, the study did not hold a rural focus and thus may be considered as presenting a more general Irish societal viewpoint.

Other peer-reviewed research which is reflective of modern Irish society in relation to this matter appears absent, however, in its stead; work commissioned by the pharmaceutical company Lundbeck, while not presented for academic scrutiny, may be suggested to offer some valuable insights in the absence of other sources. The company publishes an annual 'Barometer of Mental Health' report in which the views of Irish society in relation to a number of mental health issues are sought (For example see: Lundbeck 2009, Lundbeck 2010b).

The 2011 report comprises a presentation of data gained through the interviewing of a nationally representative quota sample of 998 adults aged 16 years and over. Sixteen or seventeen interviews were conducted at each of 63 randomly selected sampling points over a two-week period. Interestingly, a similar proportion of respondents from the 2011 survey (60%) agreed to some extent that persons of their age would be embarrassed to talk about depression to others as those who took part five years previously (64%) with approximately one quarter of the sample in each case agreeing strongly with this suggestion. Worryingly, the authors note that within the key under 25 years age category, those who agree that embarrassment would be induced has increased from 55% in 2006 to 69% in 2011 while outside of some minor favourable adjustments, overall the trends in other age categories have remained relatively static. In terms of the perceived social stigma in relation to depression, it is reported that 60% of respondents in the 2011 sample acknowledged depression as a subject of stigma, with 25% articulating that a significant stigma was attached. This outcome contrasts with another outcome in which almost two-thirds of respondents agree to some extent that 'there is less stigma associated with depression nowadays' with this agreement increasing in line with growing age, as well as with the authors contention of a decrease in social stigma towards depression over the course of the series of annual publications.

In 2010 an interesting baseline report was published as a foundational element of the Irish aspect of the Lundbeck sponsored multinational 'Lean On Me' campaign. This report (Lundbeck 2010a) was based upon data gathered in relation to prevalence and knowledge of, and stigma, perceptions and support towards depression via an online omnibus survey. Aged between 16 and 64 years, over seven thousand participants completed the survey across the countries involved. Of this Irish-based sample (n= 1,009), almost half (48%) reported that they had experienced depression while 83% said they knew someone who was affected by depression. Mindful of this level of contact and familiarity, over half (55%) of those who had experienced depression reported that they did not discuss it with family or friends, with three-quarters of this cohort saying that they felt inclined to withdraw from these potential sources of support. Reasons offered for this action included embarrassment (20%), being scared, ashamed and overwhelmed (28%), and not wanting to burden others with one's own problems (57%). While half of respondents stated that they would offer support to a family member or friend experiencing depression, contradiction in this appeared upon assessment of past experiences as approximately one-fifth of respondents who had experienced depression said they received little or no support from family members, friends or health care professionals, while a similar proportion did not offer support to a friend they knew to be experiencing depression (Lundbeck 2010a).

While providing valuable representative data, the lack of peer review and of clarity in relation to, for example, the manner in which the online aspect of the study was conducted in the latter study, or how the samples were contacted (both online in the latter study and at the sampling points in the former), undermine the strength of the studies (Van Selm & Jankowski 2006). Further, the sponsorship of the studies by a pharmaceutical company operating within the psychiatry market raises questions in relation to the potential for the existence of a conflict of interest which may undermine the validity of the findings.

One may suggest a certain discord exists in the findings of the above Irish-based studies with each piece of work holding some potential structural or methodological anomalies which may compromise significantly the validity and/or reliability of the outcomes they declare. Mindful of such concerns, the present study addresses these anomalies while addressing the shortfall of research examining stigma towards depression in rural Ireland.

Social Distance and Mental Illness

According to Marie and Miles (2008), in determining the "degree of proximity an individual is comfortable with in relation to a mentally ill target... (social distance) is recognized as a proxy measure of psychiatric stigma" (Marie & Miles 2008, p. 126). Outside of the loss of credibility and social status, the felt desire for, and imposition of social distance by others is viewed as one of the most stigmatising aspects of experiencing mental illness (Link et al 1987, as cited by Lauber *et al.* 2004). In pioneering research conducted in the USA, Shirley Star outlined findings from her vignette-based research (n=3000) from which she concluded that mental illness was something that "people wanted to keep as far away from themselves as possible" (Star 1955). Citing this work and their consistency with it over forty years later, Link *et al.* (1999) note how social distance in relation to mental illness remains a preference for a substantial portion of society. The diffusion of this distancing sentiment, citing the symbolic interactionist tones of Shibutani and Kwan (1965), occurs across society and has also been shown to manifest within the mental health profession where the social and cultural environment is facilitative in a person experiencing mental health problems being "recognised as part of an out-group... and as 'strange' in the interpersonal encounter" (Baumann 2007, p. 133). As well as, and also as a result of the demarcation, separation, and castigation experienced as a result of this process of othering (Weis 1995, as cited by Canales 2000), Bauman suggests that as with broader stigmatisation, the subject towards whom such extraordinary behaviour is directed may themselves begin to internalise the connotations of their condition and develop a similarly strange relationship with themselves.

Jorm and Oh (2009) conducted a comprehensive systematic review of the PsycINFO and PubMed databases from 1970 to August 2008 for research undertaken to measure the social distance towards those with mental illness (n=145). From their review, the authors confirm that greater social distance is desired from persons with mental illness than from those without such a condition or with other more somatic complaints. Typically this desire for distance is graded; with those experiencing substance abuse disorders the subject of greatest social distance desires, followed by those experiencing schizophrenia, and then those experiencing depression or anxiety. The authors also note that this distancing response is gendered with most studies reporting a greater desire for distance from males experiencing such conditions than females. In terms of those who desire social distance, the authors note that while there is no discernable, reliable gender difference, older

persons are generally found to be less tolerant compared to younger adults and adolescents. Suggesting the possibility of such discriminatory desires being learned through socialisation, cultural attitudes to mental health may be seen to be influential as the authors note significant cross national differences in desires for social distance with, for example, a 70% difference observable between a Japanese and Australian sample in terms of their reported willingness to live next door to a person with depression with the former desiring greater distance in this instance (Griffiths *et al.* 2006). A weak association between low education and greater social distance is also reported.

In terms of experiences associated with social distance, most notably, and with few exceptions, the overwhelming majority of studies noted that greater contact with those experiencing mental illness is associated with lower levels of desire for social distance with these findings noted "across a broad range of populations and cultures" (Jorm & Oh 2009, p. 186). Unsurprisingly, decreased social distance was also associated with those who have themselves had personal experience of a mental illness. The authors note that social distance has been suggested to increase in relation to an individual to whom a label of mental illness or a label of a specific 'disorder' has been applied due to the conception that once aware of the label, others in society gain an expectation as to how the concerned individual may behave and adjust their behaviour accordingly, i.e. by increasing their distance. From their review the authors agreed to a certain extent with this assumption, however, they note that while labelling can hold significant influence, it is the type of label applied and the familiarity of the person applying the label with mental illness which is of crucial importance in determining its impact.

Supplementing this, an aspect which appears absent from this review is developed upon by Lauber *et al.* (2004) who, based upon their vignette-based survey conducted among a representative population sample from Switzerland (n= 594), noted that social distance in relation to mental illness is seen to increase if the situations presented to respondents imply 'social closeness'. Noting responses to their Social Distance Scale, as devised by Link *et al.* in 1987, the authors state that as the level of intimacy of the proposed interaction increases, so too do the requirements of the sample for greater distance as; for example, while 2.6% of respondents stated that they were 'definitely unwilling' to work with a person with mental illness, this reaction climbed to 25.1% when the intimation is made

about the person depicted in the vignette taking care of the respondents child, and to 13.3% upon suggestion of this person marrying their child.

In a study conducted by Pescosolido *et al.* (2010), social distance in relation to schizophrenia, depression and alcohol dependence was calculated from responses to a social distance scale included in the US General Social Survey; a biennial stratified multistage probability vignette-based survey conducted on a face-to-face basis (n=1,956). Data gained was compared to a similar dataset obtained from 1996. In relation to schizophrenia and alcohol dependence, 62% and 74% of the sample expressed an unwillingness to work next to a person experiencing such conditions respectively, with each of these scores noted as a small increase on the 1996 data. Similarly, 69% of those presented with the schizophrenia vignette and 79% of those presented with the alcohol dependence vignette stated their unwillingness to accept a person with those conditions into the family via marriage, with these results noted as a 4% and 9% increase on the findings of ten years ago respectively. No significant decrease in any indicator of social distance is recorded between the two datasets. The results relating to depression are discussed below. The study is limited by its vignette-based approach whose applicability is dependent upon the appropriateness of the descriptions given, while also the authors stress caution in attributing the attitudes captured to likely behavioural outcomes.

In New Zealand, Marie and Miles (2008) conducted a postal-based study in order to understand the social distance and perceived dangerousness in relation to four mental disorders. Study packs were sent to 600 persons randomly selected from the electoral roll with a significant response rate of 72.5% (n= 435) recorded. Social distance was measured using an adapted version of the 11 item scale developed by Angermeyer and Matschinger in 1996 with responses to four vignettes depicting schizophrenia, depression, alcohol abuse and substance dependence indicated upon a 7-point Likert scale. While the scores for each individual item are absent from the paper, the authors found that there existed a general reluctance among this sample to engage in relationships of varying intensity and intimacy with any of the individuals depicted in the vignettes. Discrepancies between the mean scores of each of the conditions depicted, however, suggests that, confirming the authors hypothesis, individuals make more "fine-grained distinctions between disorders" (2008, p. 129) and thus respond to each differently as opposed to a

blanket response to 'mental illness'. The outcomes specifically related to depression are discussed later.

In a second study as part of this same research paper, the authors sought to assess whether lay perceptions in relation to the dangerousness of those with mental illness impacted upon social distance. In this instance, 101 people were recruited from a university campus, presented with the same four vignettes and asked to complete the same questionnaire administered in the first part of the study but with additional questions relating to perceptions of dangerousness included. Noting the limitation of the university-based sample upon the impact of the results produced, again in this study as in its predecessor it is outlined that there exists a general reluctance among adults to engage in relationships with those described in any of the vignettes. However, in this instance, the authors describe the existence of a relationship between higher ratings of perceived dangerousness and higher levels of desire for social distance in relation to individuals described in each vignette with, thus, those with the most feared condition of schizophrenia experiencing greater levels of social distance as the authors suggest the presence of a "psychosis-specific stigma" (Marie & Miles 2008, p. 131).

Noting the suggestion that such social distance was predominantly a characteristic of Western society and less evident in non-Western cultures, Adewuya and Mankanjuola (2008) assessed social distance towards persons experiencing mental illness in south-western Nigeria. A sample of 2,078 were requested to complete a modified version of the Bogardus Social Distance Scale as part of a wider survey. Overall results reveal poor attitudes towards those experiencing mental illness as desires for social distance from this cohort were high. Consistent with previous findings from Western studies, desires for social distance appeared to increase in line with increasing intimacy of relations suggested as while 32.5% expressed some reluctance about being engaged in conversation with someone with a mental illness, 82.4% rejected the idea of marrying such a person with 60% of this cohort choosing to strongly reject this suggestion. Surprisingly in light of this high level of prejudice, it appears that courtesy stigma may not be a significant issue among the sample as 88.7% expressed that they would not feel ashamed if people knew that a family member was experiencing such an illness. Findings from the social distance scale were supplemented by results such as the widespread belief in the contribution of demonologic factors in the causation of mental illness, a finding which is in agreement with

previous studies in Nigeria among both the general population and medical professionals. Further still, other results were indicative of the lack of contact which takes place between persons with mental illness and those unaffected by such conditions as while one-third of respondents reported that they had a family member or friend experiencing such illness, only 4.9% reported having cared for a person in this situation. This lack of contact was significant as those who had provided care were three times less likely to hold high levels of social distance than those who had not, while those placing an emphasis upon supernatural causation were also highly correlated with high levels of distance. In further agreement with previous research, older age was significantly associated with higher levels of desired distance.

While providing useful data from a developing and non-Western country, the study is limited by the author's admission that mental illness was presented as a unitary concept and thus may not have been fully understood by respondents. The authors also stress caution in attempting to generalise the findings due to the need to consider the diverse cultural composition of Nigeria and Sub-Saharan Africa.

No work of similar scale has been conducted in an Irish setting. However, within a study conducted by the National Disability Authority in 2011 (discussed above), it was noted that comfort in terms of working with colleagues with mental health difficulties was lower that with physical, hearing or vision disabilities. Further, respondents also recorded the lowest level of comfort in relation to living in the same neighbourhood as those with mental health difficulties compared to other disabilities (NDA 2011).

Social Distance and Depression

A number of studies have been conducted with the intention of gaining an understanding of social distance in relation to depression. However, it is worth noting two caveats to the conclusions reached. Firstly, often studies employ the use of a vignette, a method which is particularly sensitive to the depiction of depression offered in terms of comparability with other work. Secondly, often work assessing social distance towards depression is being conducted in conjunction with the distance desired from those with schizophrenia, a condition which typically evokes a stronger response than the former and may thus colour somewhat the tone of the responses offered (Norman *et al.* 2012). However, mindful of

these common limitations, such studies do provide significant and useful information which enhance our understanding of attitudes towards depression.

Within the work of Pescosolido *et al.* (2010) discussed above, respondents (n=676) were presented with a vignette describing depression and then asked to answer questions relating to social distance among other issues. In contrast to the two other items assessed in this research (schizophrenia and alcohol dependence), the results returned for depression show some minor improvement from the data recorded a decade previously with scores decreasing marginally in four out of the five items on the scale. Taking this development into consideration, the results produced still point to considerable social distance desired by the sample in relation to depression with over half of respondents (53%) expressing an unwillingness to accept someone with depression marrying into their family, while 47% and 30% were unwilling to work closely or socialise with someone with the outlined condition respectively.

This minor improvement in attitudes across a ten-year period contradicted work in Germany by Angermeyer and Matschinger (2004) described above which noted the public's desire for social distance as generally unchanged over an eleven year period between the publication of two cross-sectional studies. In this aspect a modified seven-item version of the Bogardus scale was employed with opinions detailed upon a five-point Likert scale. While little change is reported in attitudes towards each of the items on the scale, it is, however, notable that in spite of the progression of education and awareness campaigns within the intervening time period, 66.6% of respondents in 2001 desired social distance from those with depression in relation to the care of their child compared to 56.7% in 1990. For the remaining six items, nominal to small improvements are noted in relation to attitudes towards working with (1990= 16.5%, 2001= 15.9%) and living beside someone with depression (1990= 18%, 2001= 17.7%) together with less resistance to such an individual marrying into one's family (1990= 53.3%, 2001= 48.4%). However, some disimprovement is notable in relation one's position towards renting a room to a person experiencing depression (1990= 35.4%, 2001= 38.4%) and also in relation to introducing this person to one's friends (1990= 38.8%, 2001= 39.4%). While the studies involved are not panel based studies which may have facilitated the analysis of the possible evolution of personal thought over this time period, nonetheless, this piece

provides a key insight into the at times significant desires for social distance from those with depression which exist in a modern Western society.

Comparing cultures, in their cross-cultural research mentioned previously Griffiths *et al.* (2006) assessed social distance in relation to schizophrenia and depression using a five-item scale developed by Link *et al.* (1999). Each of the Australian sample participants received one of the four vignettes depicting depression, depression with suicidal ideation, early schizophrenia, and chronic schizophrenia while 500 people received each of the four vignettes in the Japanese sample with opinions gained via their completion of an interview questionnaire. Comparing the data yielded from these studies, the authors outline that for each of the five items on the scale, and for each of the two vignettes in which depression is depicted, those from the Japanese sample expressed a much greater unwillingness to interact with the person described, and thus a much greater desire for social distance, than their Australian counterparts. These feelings were particularly pronounced in relation to the person described in the initial depression vignette marrying into the family or living next door with 84% and 82% of the Japanese sample expressing their unwillingness to interact in this regard respectively. Highlighting the depth of difference between the samples, the corresponding figures from the Australian sample was 28.8% and 11.7% respectively. This figure in relation to marrying into the family was the highest recorded level of unwillingness to interact and was followed by those who expressed an unwillingness to work closely with the person described in the depression vignette (21%).

Overall, in both countries, the level of social distance towards depression was lower than that towards schizophrenia. The study is limited in some aspects however, and in particular in relation to the social distance aspect, the authors note that the rating scales for this item differed between countries thus impacting upon comparisons made. Other limitations include the lack of representativeness of the Japanese survey and the strong potential for social desirability responses.

As part of a study in which the stigma and social distance in relation to depression, schizophrenia, social phobia and post-traumatic stress disorder were sought as part of a national study of mental health literacy and stigma in Australia, Reavley and Jorm (2011) report that 6,019 telephone interviews were carried out with Australians aged 15 years and over presented with vignettes detailing one of the four conditions. Depression and

schizophrenia each had two individual vignettes; one for 'depression', a second for 'depression with suicidal thoughts', while schizophrenia was divided into 'early' and 'chronic' forms of the condition. Social distance was ascertained using a five-item scale developed by Link *et al.* (1999). In terms of the initial categorisation of depression, this study can be seen to compliment the work of Lauber *et al.* (2004) who suggest that desires for social distance increase in line with the increased intimacy of suggested social interaction as while there appears very few who are unwilling to make friends with (5.7%), spend the evening socialising with (8%), or live next door (8.8%) to a person with depression, a considerable number (15.5%) note their unwillingness to work closely with such an individual, while the most opposition is presented to the suggestion of marriage into the family (28.2%).

Surprisingly, this latter result decreased upon the suggestion of a more severe experience of depression which is inclusive of suicidal ideation, however, marginal increases in unwillingness were recorded across the remaining items of the scale in this instance. However, complementing the work of Griffiths *et al.* discussed above, and work conducted across the Tasman Sea by Marie and Miles (2008) (detailed in the *Social Distance and Mental Illness* section above), less social distance was desired from depression than from schizophrenia.

To the knowledge of the author no study exists which, using a Bogardus-type Social Distance Scale, enquires as to the social distance desired from those experiencing depression in rural or urban Ireland. The present study aims to contribute to addressing this shortfall.

Perceived Social Distance and Mental Illness

Very few studies deal directly with the perceived social distance desires of others in relation to mental illness in general or indeed depression specifically.

Kurihara *et al.* (2000) included a measurement of perceived social distance among their vignette-based self-assessment questionnaire distributed to office workers in Tokyo (n= 66) and the non-industrialised society of Bali (n=77). The latter sample was obtained following the recruitment of the former and was matched for age, sex, education and

occupational levels. Respondents were asked 'how would most people feel if this individual was in their neighbourhood or workplace?'. For each of the vignettes presented, those from the Balinese sample reported a lower mean social distance score than their Japanese counterparts. While in general the Japanese respondents expressed a perception that others would be less comfortable with the individuals presented in the vignettes, the Balinese respondents expressed views to the contrary as well as a greater level of optimism about their recovery also. The authors suggest that this outcome may be due to the more positive outcomes which are noted to apply to schizophrenia in particular in developing countries. These improved outcomes, they suggest, promote more positive views of mental illness and also more contact with those experiencing same thus decreasing the need for social distance. Directly relevant to the present study, the results also indicate that, interestingly, while the Balinese sample reported a lower perceived social distance mean score than the Japanese sample in relation to the depression vignette, the same Balinese sample were less optimistic about recovery from depression and attached greater levels of dangerousness to the condition also. The study is limited by its reliance upon one, non-validated question to assess same, while also its representativeness is limited by the manner in which the samples were recruited.

Perceived Social Distance and Depression

Exploring the attitudes of young people (16-34 years) towards depression and mania, Wolkenstein and Meyer (2008) recruited 387 participants from schools in Germany. Of this sample 96 were randomly assigned to provide personal responses to a vignette depicting depression, while 98 were also randomly assigned to provide their view of the responses of others to the same vignette. Cognitive, emotional and behavioural reactions, which the authors described as forming attitude, were determined via an analysis of responses on a five-point Likert scale to a modified version of the Bogardus Social Distance Scale. In line with other research which compared personal views with the perceived views of others, this study found that for each item on the scale respondents felt that others held vastly more intolerant views than their own personal beliefs in relation to the same matters. For example, the percentage of those who believed that others would not want the person described in the vignette as a neighbour (25.5%), friend (69.4%) or work colleague (57.2%) was at least double that of those who provided their personal assessment of these issues. For the remaining four items of the scale, while the

difference between the personal and perceived scores are less they remain considerable with, for example, over one-quarter more respondents viewing others as less likely to accept the person described in the vignette into their family through marriage (79.6%) than those who gave their personal view on this same suggestion (53.1%), while 84.7% of respondents felt that others would be uncomfortable with the person described babysitting their child compared to 77.1% of those who offered their personal opinions.

Aside from the above trends in the comparisons between personal views and the perceived views of others, one must also highlight the significant level of social distance both desired, and seen to be desired by this sample as, taking the cumulative percentage of the samples reporting their own views and the views of others, just over half of the respondents to the depression vignette expressed some form of discomfort with introducing a friend to the person described, while just over 80% expressed discomfort with the suggestion of this person caring for a child. The authors found that no improvement had occurred in relation to attitudes towards depression among this cohort of young people in comparison to previous studies with some evidence suggesting that some attitudes had disimproved. The authors concede that this is not a representative study as its aim was to assess the levels of stigma among a young and typically male population thus limiting the generalizability to other studies. Further limiting comparability, they note the lack of labelling used which is justified by their intention not to allow such labels prejudice responses as has been the case in previous studies. Lastly, the authors echo previous commentators in querying the strength of self-reported data in determining whether corresponding behaviours will result from the holding of such attitudes.

Similar research emerging from Ireland was absent.

Social Support and Mental Illness

As mentioned above, social support has been suggested to be of crucial importance in the avoidance of, and recovery from illness (Cohen & Syme 1985, Brugha 1989, Russell & Cutrona 1991) and is said to have positive effects upon the maintenance of both physical and mental health and wellbeing (Israel 1985, Gottlieb 1987, Acock & Hurlbert 1993, Albrecht 1994, Thoits 1995, Cooper *et al.* 1999, Cohen 2004, Uchino 2004, 2006, Smith & Christakis 2008) and quality of life (Chambers 2007). Research suggests that increased

support (perceived or actual/received) may impact positively upon the outcomes of, or the psychological distress caused by, for example, the development of HIV (Vyavaharkar *et al.* 2010), some forms of cancer (Dunkel-Schetter 1984, Nausheena *et al.* 2009), as well as psychiatric conditions including depression (discussed in greater detail below) (Brown *et al.* 1992, Brugha 1995, McDowell & Serovich 2007). But how does social support impact upon one's mental health and wellbeing in this fashion? Kawachi and Berkman (2001), while highlighting the non-exclusivity of the two models of social support operation put forward, suggest that social support operates in both a broad, structural, and targeted, functional manner in order to exert an influence upon mental health outcomes and overall wellbeing.

In relation to the structural aspect as encapsulated in the main effects model, the authors note the particular impact of social influence arguing that one's membership within a social network holds the potential to yield many potentially positive outcomes as one becomes indoctrinated into the culture of the network. The authors suggest the likelihood of such immersion leading to the acquisition of normative guidance in relation to, for example, healthy behaviours with the adoption of this advice and the implementation of the prescribed behaviours leading to the potential acquirement of salutary effects upon one's mental health. The authors do, however, acknowledge that the characteristics of the culture in existence in one's network, and the types of behaviours this promotes in this instance are significant caveats to the beneficial nature of this assertion. Continuing, the authors also note the importance of one's very presence within a network as this instils a sense of belonging, purpose, and self-worth while, further, this may contribute to one's motivation for self-care through which, they argue, physiological ability to cope with stress through neuroendocrine responses is improved. Lastly, the authors suggest that one's participation within social relationships increases the likelihood of that individual availing of social support resources such as mental health information which may act to limit or protect from the experiencing of distress.

Considering the more functional and targeted 'stress buffering' model, the authors note the suggestion that social support may directly intervene in order to prevent or dilute the impact of crisis events upon an individual, thus limiting the detrimental effects upon their mental wellbeing. Crucial in this, they suggest, is the perception that social support is available with the argument presented that an individual may make a more "benign

appraisal" of a stressful life event due to their perception that the social support exists to effectively deal with the circumstances, thus limiting the potential psychological trauma experienced.

The authors stress that operation of either or both of these models is entirely dependent upon factors such as gender, socioeconomic position, and one's life stage with the suggestion that, as an example, while emotional support is deemed of crucial importance in facilitating the healthy psychological development of children and adolescents, the application of similar levels of support towards those in old age may contribute to the fostering of a sense of dependence thus potentially undermining one's sense of personal efficacy.

A wealth of research points to the beneficial impact of social support upon mental wellbeing.

Maulik, Eaton and Bradshaw (2011) sought to explore the associations between life events, social networks, social support, and the utilisation of four different mental health services within a defined catchment area as part of a longitudinal study. Adult participants (n= 1,920) were interviewed in 1993 – 1996, with 1,071 of this sample re-interviewed in 2004-2005. Two particular variations of social support were assessed: the 'stress-reduction function' which is similar in many ways to the stress buffering or mediation model, and the 'referral function' which mirrors many aspects of the informational support aspect noted within the main effects model. In support of the stress-reduction function, higher social support received by a relative was associated with a 40-50% decrease in the likelihood of consulting with medical services in relation to a mental illness across most life events and most mental health problems. Further, the likely use of specialist psychiatry services following a significant life event was seen to decrease by 40-60% when one gained increased social support from friends or relatives, while for those experiencing mental health conditions, service use was likely to decrease by 41-60% with support from friends. Adding weight to the argument for the referral function of support, the authors also note that high levels of social support from one's spouse in the aftermath of a bereavement is associated with increased utilization of mental health services in relation to anxiety and alcohol related disorders.

While such effects attributed to social support appear positive and reflect the existence of both 'stress reduction' and 'referral function' support within the sample, the results obtained support the study hypothesis which anticipated that the effects of social networks and social support would vary across friends, relatives, spouse/partner and across life events and differing services, thus confirming a lack of consistency in the findings. The study is limited somewhat by the self-reported nature of the life events, social support and social networks, while it may be argued that the large proportion of female and white interview participants (approximately two-thirds in both instances) may somewhat limit its generalizability.

The outcomes of this research appear to mirror those of Golding and Wells (1990) which tested similar hypotheses among a Mexican American and non-Hispanic White sample (n= 3,131) using portions of a 'Dimensions of Social Support' scale. In this instance researchers found that higher social support is associated overall with a decrease in service use as this alternative source of help is utilised instead. Conversely, factors associated with low social support in one's informal network are associated with help-seeking from formal service providers.

Mental illness has been suggested to be a consistent source of discrimination (Thornicroft 2006). It has been suggested that social support may moderate the psychological distress caused by such persistent discrimination. A related example, Ajrouch *et al.* (2010) sought to understand the impact of instrumental and emotional social support in moderating the impact of everyday discrimination upon the psychological wellbeing of a sample of urban African American mothers from low-income neighbourhoods (n=969). Within the interview administered questionnaire, social support was measured using five questions taken from a locally based longitudinal women's employment study. Among this relatively young sample, the main effect of the availability of social support was negatively associated with psychological distress while in terms of the buffering hypothesis, instrumental support only acted as a significant protective buffer to those who experienced persistent moderate levels of discrimination, with its effects said to weaken in the face of more excessive discriminatory treatment. While the study is limited by its focus upon females, the brevity of the social support scale employed, and by its inability (by design) to establish a time scale between the experiencing of a discriminatory event and the reception of social

support, it nonetheless provides a number of suggestive conclusions which point to the importance of social support to the processing of psychological distress.

Further supporting the main effects hypothesis, Bovier *et al.* (2004) in their random survey of 2000 university students using the Duke-UNC Functional Support Questionnaire, found that while social support was positively related to mental health, upon conducting a bivariate analysis of the data, when stress and internal resources were adjusted for, this relationship ceased. The authors promote their suggestion that social support influences mental health via "the strengthening of social resources and/or diminishing perceived stress" (2004:169), outcomes of the main effects model.

Social Support and Depression

Though examination of the association between social support and depression has been ongoing since the middle of the 1970s, general population studies are not as plentiful as those conducted in clinical settings (Grav *et al.* 2012). Some research has questioned the benefits of social support upon the course of depression and other mental illness. For example, in an early review noting the preponderance of studies examining the perception of social support among the social network of one who is experiencing depression, Coyne and Downey note that while these perceptions are suggested to reflect the reality of relationships, research up to that point which discussed sought or received support were negatively related with adaptational outcomes (Coyne & Downey 1991). However, such findings are most certainly in the minority. Citing Helgeson (1993, 2003), Fiori and Denckla (2012) suggest that a stated negative association of support and mental health may be due to the individuals who require support being more distressed and in greater need than those who do not report receiving such support, while Takizawa *et al.* (2006) suggest this may be due to a sense of indebtedness or burden which results from receiving such support. Early research, while perhaps displaying some ambiguity in parts, more often extolled the virtues of social support in relation to depression with, for example, a similar review from only six years previous to the work of Coyne and Downey highlighting the role of socially supportive relationships in protecting against depression as 40% of a sample of women experiencing stress but without a confidant developed depression compared to only 4% of those with a confidant. This result was replicated in

other early studies though the authors also stress some methodological issues which may limit the reliability of the findings (Kessler *et al.* 1985).

More recent work has moved towards affirming the more beneficial role of social support in relation to depression. For example, in a cross-sectional community-based study, Takizawa *et al.* (2006) aimed to determine the stress buffering effects of social support on depression among a sample of middle-aged individuals (n= 4,558) in northern Japan. Informational, providing, and emotional social support were measured using ten-items derived from the Measurement of Social Support – Elderly (MOSS-E) scale. Though limited by a reduced response rate, the authors found the stress buffering effect to be enacted in relation to depressive symptoms occurring among their sample, with depression scores lower in times of stress among those with high social support and vice versa. This effect was evident only among males with other evidence suggesting that these males placed particular importance upon both receiving and giving support. The authors, suggesting cultural factors, note that this outcome contradicts previous work which asserted the greater importance of stress buffering to females than males. They also suggest that this outcome may be due to the purposeful forms of relationships in which males typically partake which are focused upon action towards a particular goal with thus reward and satisfaction gained through the achievement of said goal, in this instance the provision of support. This lies in contrast to female relationships which are seen to be more emotionally intimate.

Employing a postal survey and focusing upon gender differences, Fiori and Denckla (2012) sought to examine the association between aspects of instrumental and emotional social support and depressive symptoms in middle-aged men and women (n= 6,767) obtained as part of a longitudinal study in Wisconsin, USA. Participants were asked to state whether they had given and/or received help in relation to (a) transport, errands or shopping, (b) housework or repairs, (c) advice, encouragement or moral support, (d) babysitting or childcare to any of the following categories of people; (a) no one needed help, (b) friends, neighbour or co-workers, (c) adult sons or daughters, (d) parents, (e) brothers and sisters, (f) other relatives. In relation to the section which queried whether support was received, the category "no one needed help" was replaced by "no one available to help". Findings suggest that those who reported needing support but not having anyone available to provide it were more likely to experience the highest level of

depressive symptoms; a suggested significant risk in this instance due to the double burdens of experiencing stress and the absence of support. Similarly, the small number who reported needing emotional support and having potential avenues available from which to gain this support but yet not receiving it, also reported higher levels of depressive symptoms than those who received the required support from any source. Women appeared to benefit more from emotional support received from both kin and non-kin sources than men; however and pertinent to the present study findings, stressing the importance perhaps of kindred support, those in receipt of support from family only reported lower symptoms of depression than those reliant upon the support of solely non-family members.

Addressing the reciprocal elements of social support, the authors note that the women who stated their recognition of a level of need for support within their social network (kin and non-kin) and their provision of this support, reported the lowest levels of depressive symptoms. This outcome, confirming a study hypothesis, is suggested as reflective of the fulfilment of a nurturing function held by females who, due to the favourable physiological response to such action, gain a sense of calm within stressful circumstances and also promote the instigation of "further affiliative behaviours" (2012, p. 428). Contradicting their hypothesis, however, this beneficial element of support provision was also noticeable among male participants who, in contrast to female participants, appeared to benefit from lower depressive symptoms due to the provision of support to both kin and non-kin also. The authors also found that women who provided instrumental support to kin only had higher depressive symptoms than those who supported kin and non-kin alike in this fashion. The authors suggest that perhaps due to the acknowledgement of the broadly understood non-obligatory provision of support to those outside one's family, such recipients express a greater level of appreciation which in turn bolsters the female provider's feelings of self-worth and competency.

The generalizability of the study is limited by the "homogeneity" of its sample which comprised a cohort of exclusively middle-aged non-Hispanic white individuals with uncertainty existing as to whether the findings might reflect the outlooks of those of differing ethnic backgrounds and age profiles. The study is also cross-sectional in nature thus causality cannot be determined as to whether, for example, the presence of depression was influential in determining one's propensity or ability to seek or provide

support. Also, as acknowledged by the authors, in places the instruments used to measure social support were over-complicated, a factor which had detrimental impacts upon the data returned with a number of missing values for some aspects of the scales.

Perceived Social Support and Mental Illness

According to Cohen and Hoberman (1983), the perceived availability of social support (or perceived social support) pertains to the perception that forms of social support, with their contained elements of love, value and esteem, are available for utilization. Perceived social support has been found to be significantly correlated with the actioning of such support (McCaskill & Lakey 2000). In contrast to the traditional occupation with the structural aspects of social support which typically focused upon aspects such as the size and composition of one's social network, more recently it has been argued that this more functionally focused perception of social support, while admittedly open to the fluctuations in personality factors and affections, is perhaps a more robust and realistic measure of the concept (Lett *et al.* 2009). One may suggest that while to the observer an individual may find themselves situated within a large and dense social network and hold substantial ties of varying levels of intimacy and intensity, it may prove somewhat naïve to assert that support may be automatically forthcoming on the basis of such typically geographically centred appraisals. Contemporary attempts to reinforce this outlook are complicated by, for example, the growing placelessness of modern life (Relph 1976) and the ongoing revolution in communications said to be redefining social networks and with that social relationships and their mechanisms of operation (Castells 2001).

In relation to mental health, some evidence exists to suggest that perceived social support is a stronger correlate than received support in relation to aspects of health, personal adjustment and, independently and by association, mental wellbeing (Pierce *et al.* 1992).

Newland and Furnham (1999) sought to assess the role of perceived social support in warding against the negative psychological repercussions of homesickness, an experience correlated with increased depression, among 123 first year university students. As part of the self-report questionnaire, social support was measured using a two part Social Support Questionnaire developed by Sarason et al. (1983). The authors found that perceived social support, and not enacted support, was significantly correlated with the measure of

homesickness. Further, the measure of perceived support held a greater level of association with the measure of satisfaction than the measure of enacted support. Though based upon a cross-sectional study which did not allow for previous disruption to social networks, was focused upon young adults, and had an oversubscription of female participants, the authors argue for the inclusion of a measure of perceived social support within future assessments of homesickness.

Also recruiting a student sample, Klineberg *et al.* (2006) in exploring aspects of ethnicity, social support and mental health, engaged a representative sample of 2,790 East London adolescents (11-14 years) to complete the Multidimensional Scale of Perceived Social Support. Reporting a response rate of 89%, the authors outlined overall high levels of perceived social support among their sample with females reporting higher levels of support from friends and a special person than males. Low levels of perceived social support and support from family were associated with an increased likelihood of psychological distress, while low levels of friend, family and overall support was associated with a higher likelihood of the experience of depression compared to those who reported their perception of the availability of high levels of such support. While the focus upon those of a young age may limit the impact of this study, the ethnic diversity of the sample, the even gender divide, and high response rate are considerable strengths.

Chioqueta and Stiles (2007) examined the role of perceived social support as a psychological buffer against hopelessness as evidence suggests an association between high perceived support and decreased risk of suicidal behaviour. Again recruiting university students (n= 314), respondents in this Norwegian sample were questioned in relation to their perceptions of social support using a subscale of the Resilience Scale for Adults (Friborg et al., 2003 as cited by Chioqueta & Stiles 2007). The authors, lauding the psychological buffers addressed in their study as of crucial importance to suicide prevention, highlighted the perception of social support as "the major predictor of lower levels of suicidal ideas independent of both depression and hopelessness severity" (Chioqueta & Stiles 2007, p. 70). The results are limited to some extent by the prominence of females within the sample (77%), and also, one may suggest, by the size of the battery of questionnaires to be completed and the time required to complete (2 hours) with respondent fatigue likely.

Noting the trend towards recruiting those in university settings for such research, Tam *et al.* (2011) suggest that outside of the student based samples the findings which support the importance of perceived social support to mental health are less conclusive. In their study conducted in Malaysia, 303 students and workers aged 16-26 years took part. Perceived social support was assessed using the 12-item Multidimensional Scale of Perceived Social Support. While female respondents reported perceiving significantly higher overall levels of social support than their male counterparts, there were no significant differences in terms of mental health among the male and female respondents. While these findings are interesting, in light of the authors emphasis upon incorporating a young adult and not student-based sample, the researcher's choice of recruiting within the confines of a university setting raises questions as to the actual composition of the sample and thus its applicability as a wider population study. This point is furthered by the author's concession in relation to the local focus of the sampling thus limiting representativeness.

Perceived Social Support and Depression

In a review of the literature in relation to perceived social support and depression, Stice *et al.* (2004) outline that reported deficits in such support have been found to predict depression in adolescents with this more likely among girls and among those who perceive a lack of parental support in particular. The authors also note that due to aspects associated with the experiencing of depression such as dependency and social inadequacy, evidence suggests that social support can be eroded. Further, based on studies in which people are randomly assigned to interact with persons experiencing and not experiencing depression, the former cohort are continually rejected more than the latter.

As part of their own mixed methods study, using a survey and interview the authors examined whether deficits in perceived social support predicted increases in depression among a sample of 496 adolescent females. Perceived social support was measured using the Network of Relationships Inventory (Furman 1996, as cited by Stice *et al.* 2004) assessing companionship, guidance, intimacy, affection, admiration and reliable alliance from parents and peers. The outcomes of their research demonstrated that, at least in adolescents, deficits in one's perception of parental support, but not such perceived

deficits in peer support, predicted an increase in depressive symptoms and the later onset of depression. The authors suggest that this is the case due to the relative importance and assumed stability of parental support as opposed to the perhaps more transient support of peers. Further suggesting the relatively fickle nature of friendship ties, it was also found that the initial symptoms of depression and depression itself predicted decreases in perceived support among the sample. Generalizability of study findings are restricted by the focus upon young females only as well as by a low participation rate. Interestingly, the finding relating to family support being of greater importance than peer support contradicts that of Eldeleklioglu (2006) in which it is suggested that friendship relationships gain greater importance during adolescence as part of increasing personal independence with the importance of their maintenance continually growing.

Similar to this research, in the USA Tanigawa *et al.* (2011) recruited a convenience sample of 544 school students in order to examine the impacts of perceived social support from a number of sources upon the manifestation of symptoms of depression in victims of schoolyard bullying. Perceived social support was measured using the CASSS Level 2 inventory, a self-report measure purposely designed for children and adolescents which can determine perceived emotional, instrumental, informational and appraisal support. Childhood depression and bullying/victimisation were also measured. Among the sample, within which 12% reported clinically significant depression, the authors found greater evidence in support of the main effects rather than the buffering model of social support with its impact said to be evident regardless of the levels of bullying experienced. Separating their analysis by gender, the authors found that in support of this main effects model, social support for the girls within their sample, regardless of the level of bullying experienced, appeared to protect against the onset of depression. Girls were also more likely to perceive the importance of support from their teachers and classmates. Conversely for the boys within the sample, while a similar main effect response was recorded with the gaining of protection from depression, a buffering relation was also particularly notable in respect to support perceived to be available from the more directly influential sources of parents and close friends. Perceived social support was associated with lower levels of depression among boys who were the subject of bullying. The authors note that the study is limited by its reliance upon self-reported data which may be subject to some exaggeration, its cross-sectional nature, and, though necessary in order to answer the research question, its use of a convenience sample of young people.

Noting the limited availability of data from general population studies, Grav *et al.* (2012) undertook to investigate associations between perceived social support and depression within such a sample of 40,659 adults aged 20-89 years with valid ratings of depression in Norway. Perceived support was examined using two items; firstly examining tangible support by asking 'do you have friends that can help you if you need them?', and secondly examining emotional support by asking 'do you have friends that you can speak to confidentially?'. Responses were recorded upon a compound index of (1) low, answering 'no' to each question, (2) medium, answering 'no' to one question, and (3) high, answering 'yes' to both questions. A central outcome of the study was that perceived social support is significantly associated with HADS-defined depression across all age groups. The authors found that those who reported a perceived lack of both emotional and tangible forms of social support also reported the highest levels of depression with the strength of this association higher than that between depression and age or gender. Further, there was little difference between the associations between tangible and emotional aspects and depression even when age and gender were controlled for. When each form of support was analysed separately, it was found that a higher prevalence of depression persisted among women who perceived a lack of emotional support than men who perceived same, with the highest levels of depression in this instance noted among the eldest women lacking such support. Conversely, depression is noted as more frequent among men who perceive a lack of tangible support, indeed the highest prevalence of depression in the sample was among men who lacked this form of support and belonged to the oldest age grouping.

One may suggest that the study is potentially limited by the small scale used to determine perceived social support and also by the participation of only those who recorded a level of depression, factors which may limit its comparability to other population studies.

Summary and Conclusion

Cognisant that this research aims to query to what extent is the experiencing of depression a source of stigmatisation in rural Ireland, the driving factors behind this stigmatisation, and what impact is this having upon the opportunity for the gaining of community social support for those experiencing the condition in this setting, this chapter sought to critically examine the existent literature pertaining to personal and perceived stigma, social

distance, and social support in relation to depression. This has been achieved through an obligatory initial consideration of the research conducted in relation to the impact of each of these concepts upon the broader category of mental illness, followed by a more focused analysis of their reported influence upon depression. A brief discussion in relation to the operationalization of each concept is also presented.

A critical review of evidence from many sources suggests that a substantial stigma exists, and is perceived to exist, towards broader mental illness, and towards depression specifically, with this stigma noted as particularly strong within rural areas. Evidence suggests that this stigma is prevalent in Ireland in relation to mental illness, however, a lack of, and inadequacies within previous work means that certainty in this regard in relation to the status of contemporary depression stigma is difficult to establish. Related to this stigma, international evidence suggests that desires for social distance are noted to increase upon consideration of each of these labels, however, a lack of work within an Irish or rural context also means that substantial questions remain as to whether such avoidance occurs in such settings. In terms of social support (actual and perceived), evidence exists to suggest that it is beneficial in terms of both the prevention of and recovery from both mental illness and, as considered specifically here, depression. Again, a lack of research within an Irish or rural setting in this regard is notable.

Despite centuries of progress in science and medicine and the widespread diffusion of education based upon the principles of logic and reason, experience of depression and broader mental ill health remain the source of implicit and explicit fear, prejudice, and discrimination across global society. Owing to this, the contemporary social environment must then be seen as one in which the freedoms and essential identities of those who experience such conditions are curtailed relative to others within society.

While the level of personal stigma held may generally be low, that those experiencing depression receive a distinction, and indeed that stigma exists at all, amounts to its effective justification and thus must be addressed. Furthermore, and perhaps even more importantly, one may argue that the consistent trend emerging across the use of varying methodologies and sampling strategies in which research participants outline their vision of a wider society grossly intolerant to such aspects of mental distress represents acknowledgement and acceptance of the existence of a residual culture in which mental ill

health, including depression as discussed, remains mired within the realm of social deviance.

In Ireland, gaining a full perspective of the stigma towards both depression and broader mental illness is inhibited by the dearth of contemporary and relevant research, a deficit which one may suggest is indicative of the historical sensitivity of, and secrecy towards such issues within Irish society and the significant barriers this has posed to engaging the community in associated research endeavours. As is noted, this situation is beginning to change with this movement being bravely led by those experiencing such conditions through their participation in emancipatory forms of research. Mindful of this contribution, and the certain momentum this affords, the present study contributes to the emphasis now being placed upon the wider community, in doing so challenging the structures and prevailing culture within the shared social environment, an aspect understood to play a significant role in determining the onset and ultimate course of depression and mental distress.

Although the studies discussed provide valuable contributions towards explaining the stigma towards depression and the impact of social support upon this, the paucity of the research in this regard relating to other western European countries in general, Ireland, and indeed to rural Ireland in particular where the effects of depression are reported to be felt so severely, provide the impetus for a greater exploration of these issues in order to contribute to the global and local efforts to remedy the prevailing social circumstances. Hence, this study, through the employment of mixed methodologies, explores the stigma towards depression and the impacts upon social support in rural Ireland.

Chapter Four – Research Methodology

The purpose of this chapter is to provide a detailed outline of the philosophies which underpin this research and to detail the strategies which were employed in its completion including sampling, recruitment, data collection and analysis. The rationale in relation to the techniques and instruments used in order to meet the study aims and objectives is also discussed.

Methodological & Philosophical Issues

Pragmatism

Citing Kuhn (1962, p. 24) and Mills (1959), Feilzer laments the seeming obligatory nature of choice between dichotomous paradigms which had persisted until relatively recently noting the potential for such an enforced selection to "constrain intellectual curiosity and creativity, blind researchers to aspects of social phenomena... and limit the "sociological imagination"" (Feilzer 2010, p. 7). To counter this threat, this study seeks to adopt an "anti-dualist" (Rorty, 1999 as cited by Feilzer 2010, p. 8) pragmatic worldview in order to serve the research question appropriately. A stern rebuff to arguments for the hegemony of positivist scientific realism in research, Cherryholmes (1992) seeks to define the basis for pragmatic research as an approach that "seeks to clarify meanings and looks to consequences" (1992, p. 13). It is an approach that casts an interrogatory eye upon the issue of concern. Acknowledging the limits of knowledge, the approach rejects the notion of a full and unquestioned understanding of reality, in doing so promoting informed research through the discovery and utilisation of a wide range of possible theoretical approaches and research methods based upon the stipulation that they ultimately serve to meet the desired outcome; "beginning with what he or she thinks is known and looking to the consequences he or she desires, our pragmatist would pick and choose how and what research to do and what to do" (Cherryholmes 1992, p. 14).

In Morgan's paper from 2007, the author notes three central advantages of the pragmatic approach – abductive reasoning, intersubjectivity, and transferability. Abductive reasoning relates to the connecting of theory and data in which the researcher has the ability "to move back and forth between induction and deduction" (Morgan 2007, p. 71).

Intersubjectivity is suggested to span the chasm between proponents of the need for the utter objectivity of the researcher and those who view subjectivity as an unavoidable and inseparable aspect of research. Typical of its unifying nature, this approach suggests a revision of the "forced dichotomy between (the) subjective and objective", between qualitative and quantitative, in favour of an accentuation of the potential for progress with the implementation of joint projects (Morgan 2007, p. 72). Lastly and in a similarly uniting tone, the pragmatic quality of transferability is said to promote a corroboration of evidence from qualitative and quantitative methods with a view towards the reusing of knowledge in differing contexts, thus provoking a level of reflection as to the ultimate objective of the particular research agenda (Morgan 2007).

A wholly liberating approach, free from possible detention within restrictive and polarised philosophical encampments, one is at liberty to explore differing philosophies, research methods, worldviews, and assumptions, and with that differing forms of data collection and analysis. "Truth is what works at the time" (Creswell 2009, p. 11) but with a constant view upon a solid rationale for same. The pragmatic worldview is therefore included in the present study due to its inclusivity and boundlessness which encourage the exploration of traditionally differing or competing methodologies and worldviews "thus enab(ling) researchers to enjoy the complexity and messiness of social life and revive a flagging social imagination" (Feilzer 2010, p. 14).

Mindful of the all-inclusive nature of the pragmatic approach, this study also leans heavily upon the social constructivist and advocacy worldviews. Social constructionism, an approach that gains particular importance in the dominant qualitative aspect of the study, recognises the need within each individual to understand the world in which one resides and the culturally loaded context within which this need is realised. This approach focuses on the role of interactions within this loaded context and seeks to understand the significance and efficacy of the "historical and cultural norms that operate in individual's lives" (Creswell 2009, p. 8) with an underlying assumption that it is essentially the "interactions and beliefs of people (that) create reality"; it is "a product of social processes" (Neuman 2006, p. 89). In the present study, it was imperative that these processes, manifest in language, beliefs and interactions, were explored.

The advocacy worldview perspective may be seen as complimentary to both the overall pragmatic approach highlighted above, and also the supplementary social constructivist approach and thus is also included herein. Reiterating a central aspect of the pragmatic approach, this worldview is removed from a notion of research conducted in isolation but instead has a definite focus upon consequence and is intertwined with, and driven by, an agenda of concern and reform. Its links with social constructivism are emancipatory in nature and based upon a premise that social and cultural norms, acting to frame social understanding, are legitimate targets in attempting to remedy the studied social malaise which may be contributing to marginalisation of particular cohorts in society (Creswell 2009). This approach encourages a focus upon these interactions and norms, questioning their significance and understanding, via interpretation "shaped by the researcher's own experiences and background" (Creswell 2009, p. 9), the implications for how they shape society. Thus the participant in this research is encouraged to adopt the role of the researcher in their description of interactions, context and perceived cultural norms.

Mixed Methods Approach

Primacy in terms of a decision in relation to the type of methodology to employ must lie within the consideration of which approach will best suit the research question (Doyle *et al.* 2009, Rauscher & Greenfield 2009). In line with the adoption of the pragmatist worldview, and mindful of the assertion by Creswell that "there is more to be gained from the combination of both qualitative and quantitative research than either form by itself" (Creswell 2009, p.203), this study utilizes a mixed methods strategy of enquiry. The central reasoning for this adoption lies in the consistent satisfaction of criteria for the achievement of the highest level of understanding of the phenomenon under investigation. A mixed methods approach acknowledges the value inherent in both qualitative and quantitative fields and the potential that exists for an ever greater understanding of social phenomenon were these traditionally polarised and segregated approaches to be united towards a common purpose (Onwuegbuzie 2002). As suggested by Greene (2007), the adoption of such an approach is not merely a display of favouritism towards a practical and sufficient way of answering a question, but is about the development within the researcher of "a mixed methods way of thinking... (which) rests on the assumptions that there are multiple legitimate approaches to social enquiry and that any given approach... is inevitably partial" (2007, p. 20). It is a form of critical thinking, of reflexivity, of

perseverance; noting the philosophical frailties of two broad approaches but in doing so, seeking to move beyond futile arguments of bettering towards a reconciled position which offers greater strength and purpose than each approach in isolation (Greene 2007). While most often associated with the unification of the two main and opposed schools of thought, it is the promotion of multiplicity which lies at the heart of mixed methods research with the consideration of multiple perspectives, viewpoints and positions a consistent feature (Johnson *et al.* 2007). As a fundamental principle, mixed research should involve the combining of quantitative and qualitative methods, approaches, and concepts that have complementary strengths and non-overlapping weaknesses (Brewer & Hunter, 1989 and Johnson & Turner, 2003, as cited by Onwuegbuzie & Burke Johnson 2006).

So how, then, can the inherent partialities of individual methods and the threats they pose to validity be countered using a mixed methods approach? In their classic text which assisted in defining the field of mixed methods research at the time, Greene, Caracelli and Graham (1989) outline the five central purposes of mixed methods research stressing continually the potential for synergy and progress to be gained through what had previously been perceived as weaknesses. In their typology, the authors discuss triangulation through convergence, the potential complementarity of results, the development of outcomes, the role of the outcome of one method in initiating analysis of another, and facilitation of expansion of the breadth and range of enquiry. Each method, then, while differing in specific content, is yet held together by a common thread of an ability to increase the understanding of a particular phenomenon above the realms of understanding deemed possible via a singular methodological approach (Greene *et al.* 1989).

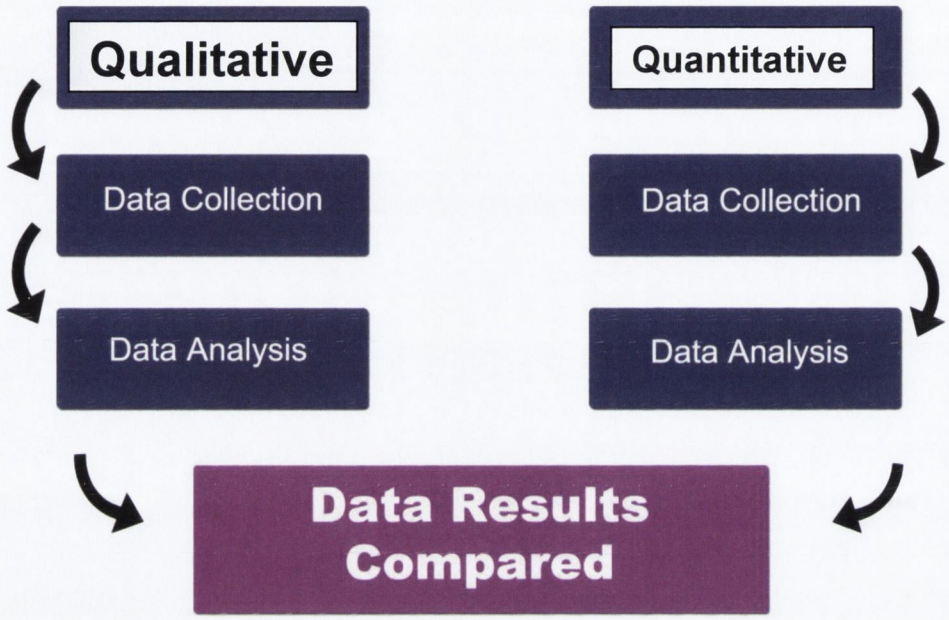
Study Design

Concurrent Embedded Mixed Methods Design

This study incorporates a concurrent embedded mixed methods research strategy. As presented diagrammatically in Figure 1 (below), this approach incorporates the simultaneous collection of quantitative and qualitative data, followed by the separate analysis of each dataset towards the eventual mixing of the data. This approach distinguishes itself from similar approaches, most notably the triangulation models, by its

reliance upon a primary method to guide the overall project, with the secondary method occupying "a supporting role" (Creswell 2009, p. 214).

Figure 1: Concurrent Embedded Design



Source taken from Creswell J.W. (2009) *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*. 3rd edn. Sage Publications Ltd., London.

Weighting

According to Rauscher and Greenfield, "if a study's primary aim is discovery, exploration, or thick description and meaning, the qualitative component of the study takes priority" (Rauscher & Greenfield 2009, p. 94). Thus, in the present exploratory work, the quantitative aspect is given less priority and nested within the dominant, primary qualitative methodology. In its supporting role, the outcomes of the quantitative aspect served to provide statements and themes which supplement the already established interview schedule elements, while also being employed to assist in the maintenance of the structural element of the semi-structured interviews throughout qualitative data collection. The outcomes of the quantitative aspect are embedded within the qualitative findings in order to enrich the detail offered. This approach aimed to facilitate the gaining of an in-depth understanding of the lived experiences of study participants and their perceptions of

their world via the establishment of an research environment in which rich detail may be provided in relation to culturally constructed and guided values and beliefs (Bradley *et al.* 2007).

Variant Approaches

Mirroring some aspects of the more sequential designs, within this concurrent approach in the single data collection phase, as discussed in greater detail in the *'Field Administration of Data Collection'* section below, the later qualitative aspect is, to an extent, "inform(ed)" by the initial quantitative aspect which produced outcomes forming the basis for some further discussion and enquiry (Creswell 2009, p. 211). Further, and with particular reference to explanatory designs also, this study employs aspects from both the "follow-up explanations" and the "participant selection" variant models noted within this broader design. The former variant model is noted for its ability to harness qualitative data in order to provide an explanation or expand upon quantitative data collected in the initial element of the data collection phase of the research. The latter model recognises the role played by an initial quantitative phase in providing the research with a level of dynamism by identifying and recruiting participants for a series of in-depth qualitative interviews. In this instance, the quantitative questionnaire served as a point of focus, an introduction to the study, and a stimulant for further thought, interest, and ultimately the desired participation in the later qualitative aspect of data collection (Creswell & Plano Clark 2007).

Ethnographic Emphasis

The overall qualitative approach to this study leaned heavily upon an ethnographic tradition of research which focuses upon the examination of a culture using descriptions that are extracted through gaining the perspective of those who are based within it; "culture, the object of our descriptions, resides within the thinking of natives" (Franke, 1983:61 cited in Neuman 2006). The researcher is necessitated to engage with the cultural entity under consideration and employ a variety of methods ranging from observation to interviewing in order to ascertain an implicit and explicit cultural knowledge of the grouping. Explicit knowledge may be more easily discernable as it is often centred upon common social practices played out without concealment which, on the surface at least, are accepted as normal pursuits. Enquiry eliciting thick descriptions pertaining to the intricacies of social practices and interactions may prove most effective in this instance.

The exploration of implicit or tacit knowledge, however, requires a greater breadth of enquiry but with that, to the qualitatively focused researcher, yields greater rewards as it encompasses and queries the "unspoken cultural norm" (Neuman 2006, p. 382) which may itself be directing the social actions acknowledged through explicit knowledge. As well as a greater depth of enquiry, significant emphasis must be placed upon analysis of such data as it is through this that the themes and meanings, the unspoken aspect, may be determined.

Hennink, Hutter and Bailey (2011, p. 47) provide a list of the requirements of a researcher adopting an ethnographic approach to fieldwork. This list is repeated below:

- Wish to understand a community, village, or neighbourhood.
- Wish to get a holistic picture of a situation.
- Aim to achieve a deep insight into the lives of the study population.
- Seek the insiders point of view (emic perspective).
- Wish to understand the (cultural) meaning attached to the research issues.
- Have a theory of culture underlying the research.
- Seek to participate in the life of the study population.

The aims and objectives of the present study comply with all but the last entry on this list. Therefore, mindful of the lack of participation, this study adopts what Gold (1958) described as the "observer-as-participant" approach. In his own description, Gold adopts a less than complimentary tone towards such an approach asserting that the brevity of interaction with participants typically through interview, can leave the researcher feeling threatened, disconnected, and confused by the little data he might collect. Noting the date of Gold's commentary, contrary to this, one may argue that in certain circumstances, as in the present study, such an approach may prove most desirable as it may be more in tune with the requirements of conducting contemporary research. Whereas previously participants and researchers may have had greater time resources and less ethical preconditions to establish in-depth relationships, modern society, noted by its faster pace of living, makes such an approach impractical in all but a few scenarios. Further, often the subject matter of the research being undertaken means that relatively short, more anonymous-feeling interactions are both sufficient and desirable as they allow for the disclosure of perhaps 'politically incorrect' information confidentially and to a relative stranger without the trappings of guilt and/or embarrassment which may arise through

relationship formation which may distort the conveyance of a felt opinion. Finally, and moreover related to the type of research being undertaken, such an approach may be most suitable when opportunities for the sort of genuine interaction described are few due to practical reasons such as, in the instance of this study, where a particular 'community' under investigation is not bound to one particular geographical location but instead spread across space making immersion among such a 'community' or cohort impossible, or using the example of Norris (1993) as cited by Bryman (2008), where legal or ethical considerations prevent such interaction, covert or otherwise.

Aside from the obvious ethical implications of observation, Bryman also notes that often the emphasis upon it proves simply unfeasible as the resources of time and money required to complete this form of approach in its entirety are rarely at the disposal of researchers. Bryman suggests that to counter this but yet maintain the very essence of the approach, as highlighted above, research based exclusively on interviews have become increasingly popular. In this instance, the level of engagement is somewhat adversely affected, however, with careful consideration of strategy; the essence of the research remains unaffected (Bryman 2008).

'Hard to Reach' Populations

A good definition of 'hard to reach' individuals or populations emanates from a UK Health and Safety Executive report from 2004 in which an articulation of those who are "inaccessible to most traditional and conventional methods for any reason" (HSE 2004) is supplied. As a brief review by Flanagan and Hancock (2010) uncovers however, such a broad term and equally broad definition leads to the inclusion of varying groups from sex workers to asylum seekers while also spanning those marginalised by society to those who consciously decide to detach from it. While the debate for a conclusive definition persists, Flanagan and Hancock point out that regardless, engagement with such populations and addressing their under-representation in research is an important consideration (Flanagan & Hancock 2010). The supplied definition may be seen still, in its nearing acceptance of the exhaustion of conventional approaches, as posing a challenge to the research community; to utilize researcher creativity and resources to form new approaches to bridge the apparent gap and assist in an unknown or silenced voice in being heard.

It has been suggested that rural populations fall within the realm of 'hard to reach' or 'hidden' populations in terms of research potential as qualities inherent in the grouping create obstacles that make establishing contact and conducting research with this cohort challenging in both practical and methodological terms (Brackertz et al. 2005 as cited by Brackertz 2007). An example of this may include the frequent geographical isolation and wide distribution of rural dwellers which can have the outcome of increasing financial and time requirements in order to effectively implement a research plan in such settings. One may also suggest that due to the lack of a tradition of the inclusion of those in rural areas within research studies, a culture which embraces and promotes participation in such endeavours may be absent thus presenting further challenges in relation to obtaining sufficient interest and ultimately contributions to a suggested study. Faced with such obstacles, the present study contributes to the drive to continually adopt new approaches that foster inclusion.

Internet-Based Research

Matthews and Cramer highlight that "recent technological innovations offer researchers alternative options for recruiting hidden populations" (2008, p. 302). Information Communication Technologies (ICT) and web-based approaches now allow the opportunity to communicate in a meaningful way with previously concealed populations (Wellman & Haythornthwaite 2002a). Across the developed world, web-based communication has increased at pace over the past decade as we move from an almost elitist and digitally divided "world of internet wizards to a world of ordinary people routinely using the internet as an embedded part of their lives" (Wellman & Haythornthwaite 2002b, p. 6) (Wright 2005, Hampton *et al.* 2011). Email, for example, upon which the present study relies as a method of distribution, is now more frequently used as a form of communication than the telephone with its popularity attributable to its instantaneous nature, its dependability, security and affordability (Levy 2001, Wellman & Haythornthwaite 2002b). Web based technology now permeates through every aspect of our society with "core economic, social, political, and cultural activities throughout the planet... being structured by and around the internet" (Castells 2001, p. 3).

According to data compiled in June 2012, approximately 34% of the world's population now use the internet with a growth rate of 566% witnessed since the year 2000. Across

Europe 63% of the population are internet users with a figure of 76.8% of the population reported for Ireland in this regard (IWS 2013). According to the Irish government broadband is now available to 99% of the Irish population (DCENR 2010). Such considerable expansion in both the availability and usage of the internet suggests that the environment is now suitable to harness and channel the considerable potential held by internet-based research.

In a review of the advantages and disadvantages of conducting online research, Wright (2005) describes how with appropriate collaboration or levels of access, interest groups can now be approached and have their voices heard through research conducted with their assistance. This approach to accessing (directly or indirectly) information in relation to previously inaccessible cohorts has already been developed by many health researchers who have also recognised the benefit for the previously excluded, potentially hesitant, or perhaps even socially stigmatised research participant who is afforded levels of potential anonymity and control over their participation in the research process which may not have been perceived to be guaranteed in offline research encounters (Braithwaite, Waldron and Finn 1999 as cited by Wright 2005, Johnson 2003 as cited by Markham 2011). Markham (2011) also highlights the perceived anonymity of internet interactions which, she feels, is due to an understood disconnection from geographical markers afforded by online pursuits as internet communication is understood, implicitly or otherwise, to show disregard for location and distance.

This level of control over one's study participation and distance from researchers may also have the effect of yielding a more accurate response from participants who may feel less constrained about expressing views that one may find difficult to articulate under the glare of a researcher diligently noting one's every word. This characteristic of online research, is of paramount importance to the present study as, as is discussed throughout, the subject matter is traditionally perceived as one of social discomfort and contention which, in the view of the author cognisant of existing literature, merits an approach where a level of distanciation from one's opinions may provoke interesting results.

Evans and Mathur (2005) discuss the major strengths and potential weaknesses of online surveys. Included among the major strengths of this approach are the significant reach enabled and the ease of obtaining large samples relative to conventional methods of

sample engagement, the speed of data collection, and the convenience primarily for the prospective participant. Supporting such points, Wright concludes his brief analysis by focusing upon two crucial aspects in support of internet based research appearing consistently in the literature and which can be viewed as directly relevant for the present rural based study; the opportunity to save time via the negation of the need to cover sizeable geographic distances in order to survey the desired sample, while also, and related to the previous point, the significant cost saving to be expected by avoiding costs potentially accrued through such travel or through payment for the postage of hardcopy questionnaires for example (Wright 2005). Markham also views the internet as "chrono malleable" (2011, p. 118), due to the mixture of asynchronous and synchronous interactions online. This quality is suggested to produce a desirable side effect of providing the opportunity to the participant "to reflect and revise utterances and actions" (2011, p. 119) thus providing a possibly more considered and perhaps more accurate response. While one must also be considerate of the potential weaknesses in this approach, one may contend that a number of such weaknesses can be rectified in a relatively simple manner through a considered research strategy combining robust ethical review, careful and informed survey design and implementation planning, collaboration with a gatekeeper, and compliance with national and international laws.

While one must be mindful of the unequal nature of access to and utilization of internet-based communication technologies and how this digital divide can serve to marginalise the internet 'have-nots' and also the traditionally disadvantaged in society along ethnic, educational and wealth lines (Castells 2001), one must also recognise the significant research opportunities presented by such technological developments and that "the internet is not only a technology but an engine for social change" (Jones 1999, p. 2). One must embrace such opportunities knowing that such endeavours can advance society primarily through the production of valuable research contributions, while also using the processes of research itself to possibly inform and engage with those previously lacking in technological literacy or research participation, in doing so assisting in the bridging of this divide even if incrementally.

Research Methods

The concurrent embedded mixed methods approach employs the use of both quantitative and qualitative research methods.

Quantitative Research

Quantitative methods are bound within a positivist philosophy centring upon the notion of absolute truth of knowledge, the essential measurability of phenomenon, and sees the role of social science as being to discover causal laws which account for human behaviour. Positivism is deterministic in essence and based upon an understanding that human action is driven exclusively by rational thinking. In a value free environment in which the researcher is invariably detached from the subjects involved, using a highly organized, formal and systematic "reconstructed logic", quantitative methods "emphasize precisely measuring variables and testing hypotheses that are linked to general causal explanations" (Neuman 2006, p. 151) of the phenomenon under investigation (Neuman 2006, Creswell 2009).

Further to the argument advanced above in relation to a deemed inherent bias towards positivism which has been seen to define mixed methods research, this study is adopting a predominantly qualitative approach. Consistent with this standpoint, the strengths and qualities of the quantitative approach as highlighted above will be utilized in order to provide a foundation upon which a wider, more expansive qualitative aspect will be based.

Qualitative Research

The ethos surrounding qualitative research can be summarised in the call for researchers to adopt a stance towards interpretivism in conducting their work, an idea rooted in the work of Dilthey and Weber cited in Hennick, Hutter *et al.* (2011) centred upon gaining an "emphatic understanding... of the everyday lived experience of people" (Neuman 2006, p. 87) - termed in the classic literature as Verstehen. This level of understanding is distinct as it moves beyond the researcher's own interpretation of issues discussed. Denzin and Lincoln (2003), in their almost forced, broad definition, describe qualitative research as "a situated activity that locates the observer in the world" (2003, p. 4). In this account, mindful that both the observer and the world around them interact, and within the assertion that a greater understanding can be achieved in this way than when the researcher is

distanced, either physically or methodologically or both, the emphasis is placed on absorbing the context and meaning of the interaction with the research participant. The desired outcome is the creation of an understanding of the lives of those studied "from their own perspective, in their own context and... using their own words and concepts" (Hennink *et al.* 2011, p. 17). To achieve this end, the researcher, while of course obliged to seek proficiency in the use of the tools of such research, must also engage more of themselves in the process and develop qualities, or develop upon pre-existing qualities of listening, empathy, flexibility and open-mindedness within the natural settings of participants in order to elucidate communication from participants that act as a window to their lived experiences and understandings. Through this, then, a qualitative researcher can attempt to "make sense of, or to interpret, phenomena in terms of the meanings people bring to them" (Denzin & Lincoln 2003, p. 5) – the very essence of qualitative research.

Implicitly with the adoption of this framework, such research, based upon a participant's divulgence of their understanding of their own reality, is acknowledged to be based upon notions of constructionism or more particularly that of the social nature which maintains a focus upon "social realities (that) are constructed and sustained by the observation of social rules" (Greenwood 1994, p. 85, as cited by Crotty 1998). Such an approach, while fraught with potential pitfalls the avoidance of which requires methodological discipline, is also ideal for social research for it offers the unique opportunity to uncover the dynamics of the "world of meaning" we are born into in which "a 'system of intelligibility' prevails" (Crotty 1998, p. 54) directly from the inhabitants of this world versed in its culture and codes.

This assumption then forms the inductive basis of this methodological approach, as the effort is placed into ascertaining the knowledge of the participant with a view to this knowledge informing a later developed theory about the subject matter.

Sampling

Study Population

The study population, defined as "the entire group of individuals, groups, or objects to which you would like to generalize your research results" (Sue & Ritter 2007, p. 25), is the population of rural Ireland. Further to the above commentary on hard to reach populations

and noting the inherent impracticality of attempting to reach the entirety of this section of society, a sample frame of the rural population was devised.

No single agreed definition of rural exists. Instead, numerous authorities have made attempts to classify what is rural on the basis of, for example, population density parameters and land usage with the concept applied in different ways across differing regions and states (Walsh 2010). Walsh notes that while there is ambiguity in relation to the criteria which defines rural in relation to public policy, that "most people know what rural is, defining it by geography and by social and imagined constructions" (Walsh 2010, p. 6). Cognisant of this, for the present study participants were allowed to self-identify as being rural with no exclusion criteria outlined outside of the explicit mention in all study related materials that it was the views of those in rural Ireland that were being sought.

Sample Frame

The author reached a collaborative agreement with Irish Rural Link (IRL), a national organisation representing almost 500 community groups across Ireland claiming an approximate combined affiliate membership of 25,000 (IRL 2011), to contact their membership via email in relation to the study. IRL thus assumed the role of gatekeeper. The affiliate emailing list of IRL, which formed the sample frame of the study, contained approximately 240 email addresses. Emails sent to affiliates typically include a request to the receiver to distribute further to those within their own networks where appropriate, however, IRL held no means of determining if this request is met. IRL is aware that often affiliated organisations are voluntary in nature and administered on a part time and/or casual basis by a small number of staff or, in some cases, a single individual. The recent economic decline in Ireland has led to funding cutbacks resulting in many community based organisations reducing or ceasing their operations (Rogers 2011). The extent of this reduction in community services which are affiliated to IRL has become apparent in many ways including the witnessing of a rise in the receipt of 'undeliverable' responses to IRL mail outs from email accounts that have been discontinued due to the folding of an organisation. The author was made aware of these conditions from the outset in order to develop a strategy which could maximise participation given such constraints.

Response Rates

As with all conventional methods of conducting research, obtaining the maximum response rate is a constant concern when using web-based approaches, becoming an issue which has garnered much attention from methodological commentators and practitioners alike (Couper 2000, Yun & Trumbo 2000, Sheehan 2001, Kaplowitz *et al.* 2004, Tourangeau 2004, Heerwegh 2006, Michaelidou & Dibb 2006, Van Selm & Jankowski 2006, Al-Subaihi 2008). Using web-based surveys, it is deemed impossible to accurately calculate a response rate with any level of certainty due to the inability to quantify how many persons come into contact with the questionnaire and decline to take part (Van Selm & Jankowski 2006). While such a constraint presents a challenge to those planning research using such surveys, others have proceeded to produce work detailing and comparing response rates using differing web-assisted approaches. Perhaps given the confusion of how response rates may be calculated it is unsurprising that of those reported, rates vary along a broad spectrum from 20% to 70% (Sheehan 2001, Andrews *et al.* 2003, p. 191). Differing approaches to engagement with the sample frame and also following up with same, both crucial to the maximisation of participation and yet also highly dependent upon the individual piece of research, also make a like-for-like comparison of rates difficult.

Reviewing factors influencing response rates to email surveys, Sheehan (2001) notes the debate in relation to the sending of pre-notifications to potential respondents prior to the distribution of the study survey. Sheehan cautiously concludes that such pre-notification, in combination with a measure of tactfulness, is "imperative" due to its association with the generation of prompt returns and also due to its role in atoning somewhat for any mild annoyance suggested to be caused to the recipient by unsolicited emails. In relation to following up on an emailed survey, Sheehan details how a reminder email can increase responses in email surveys by up to 25% (Sheehan 2001).

Mindful of the above review, a carefully considered pre-notification email was distributed to the sample frame one week prior to survey distribution. Three weeks after the mailing of the study email, a follow-up email was sent in order to remind the recipients of same and encourage participation and further distribution of the study email to those within their networks/community organisations.

Nonprobability Sampling

In one of the most up to date and relevant guidebooks on the subject of conducting online surveys, Sue and Ritter (2007) discuss sampling strategies for web-assisted research. While accepting the sustained conventional wisdom contained in most statistical texts in relation to the potential inferiority of nonprobability sampling, the authors acknowledge that "while this advice is often theoretically sound, in online survey research it is often impractical" (2007, p. 32) for reasons such as the unlikelihood for most researchers of obtaining large databases of email addresses to potentially include in the study, or of having the finance to support other larger scale study implementation plans. The authors, echoing the sentiments of commentators on pragmatic research, stress the primacy of the study objectives and their role of determining the most suitable sampling methods and, in an encouraging tone directed towards those limited to such sampling techniques but who fear for the integrity of the study data resultant from this approach, citing Hill (1998), note that "it is better to have collected some data and gained some insight than to have collected no data and gained no information" (2007, p. 34).

Mindful of the constraints in relation to contacting those within the sample frame discussed above, this study intended to gain the broadest sample possible through the implementation of a snowball sampling technique. This method is "based on using social networks in the community and shared knowledge about individuals" (Hennink *et al.* 2011, p. 101), in order to realise the potential for participation of individuals situated within the networks of affiliates but who may not have been original recipients of study material due to their non-affiliate status. Such an approach has been chosen as it crucially also holds the essential inclusive quality of an ability to potentially incorporate those in hard to reach populations whose voices may have otherwise remained unheard and outside the reach of the research to the great detriment of the study and, consequently, the overall discourse (Faugier & Sargeant 1997, Atkinson & Flint 2001).

Data Collection

The distribution of a detailed study-focused email to those within the sample frame, i.e. the membership of the gatekeeper organisation Irish Rural Link, was central to both quantitative and qualitative data collection. This email (see Appendix 2) contained an introduction to the research, hyperlinks relevant to both aspects of the study, together with

all supporting informative materials and contact details of those connected with the study. In keeping with the snowball method of distribution (Biernacki & Waldorf 1981), recipients were requested to distribute this email further to those within their own network of family, friends, colleagues etc. Participation in this study was restricted to those 18 years of age or over.

Quantitative Data Collection

Quantitative data collection was achieved by recipients of the above detailed study email following the enclosed hyperlink to the questionnaire survey hosted online and following the instructions there to complete the survey.

Questionnaire Design

The questionnaire was devised following the careful consideration and critical review of the literature in relation to depression stigma, social distance, and social support. Further to basic demographic information, a number of instruments have been employed in the design of the study questionnaire.

A depression stigma scale, devised by Griffiths *et al.* (2004), is included with the aim of gaining an indication of the level of stigma that exists in relation to depression. The scale was devised based upon recurring themes on websites on depression and stigma and on themes that emerged from results returned by the Google search engine for the keywords of 'stigma' and 'depression'. The scale is divided in two, the first aspect asks respondents to rate their personal feelings in relation to a statement provided, while the second aspect asks the respondent to indicate how they believe others would respond to the same questions, their perceptions of others' opinions. The statements include a number opinions in relation to beliefs about depression and those with the condition while also providing responses to social situations with the respondent asked to rate their agreement or disagreement with the statement. Responses are recorded using a five point Likert scale. The depression stigma scale has been employed in studies focusing upon both adolescents (Calear *et al.* 2011) and adults (Coppens *et al.* 2013), and has also been employed in cross-cultural work (Griffiths *et al.* 2006). In terms of internal consistency, in a study in which the scale was administered to a sample with raised scores on a depressive

symptom assessment scale, the personal and perceived scales recorded Cronbach's alpha's of 0.72 and 0.82 respectively and 0.78 in total each suggesting good levels of consistency (Griffiths *et al.* 2004).

In order to understand the levels of perceived social support, modifications were made to a perceived social support availability questionnaire, kindly provided by Dr. Kristin Mickelson of Kent State University, USA. The questionnaire is itself an adapted version of the UCLA-Social Support Inventory which places emphasis upon the emotional, informational and tangible aspects of social support. Respondents are asked three questions which aim to judge the perceived comfort of others in interacting with someone experiencing depression in a range of supportive scenarios. Again, respondents are asked to rate their perceptions of others' opinions on a five point Likert scale. In a study in which parents of children with special needs were interviewed using the scale a Cronbach's alpha of 0.70 was recorded which suggests a good level of internal consistency (Mickelson 2001, 2011, personal communication).

Pertinent to both social support and stigma, in order to understand the degree of potential contact with those experiencing depression, an adapted version of Social Distance Survey (SDS) devised by Angermeyer and others (1987), and cited in a further adapted form by Lauber (2004), is included. This scale holds seven statements which question the willingness to interact socially with a person with depression in a range of scenarios which vary in their prospective levels of physical contact and emotional intimacy with everyday situations considered along with more intense and consequential hypothetical relationships. Respondents again asked to provide their perceptions of others' opinions using a Likert scale. When used among a representative sample of the population in Switzerland (n=594) assessing personally held desires for social distance from those with mental illness, the scale recorded a Cronbach's alpha of 0.86 suggesting a good level of internal consistency (Angermeyer *et al.* 1987, Lauber *et al.* 2004).

Qualitative Data Collection

The sample for the qualitative aspect of the study emerged from those who indicated their willingness to take part in the interview process via completion of a dedicated section at the end of the online survey. This research-based recruitment is noted for its practicality

as it holds the potential for the appropriation of greater depth of information from participants who are already versed in the study. Such immersion and familiarity with study aims, objectives and subject matter yields a level of comfort and familiarity with both the study material and the researcher/prospective interviewer. The option of registering interest in taking part in the interview without completing a questionnaire was also presented. Those who indicated their willingness to take part in this aspect of the study were immediately contacted by email in order to arrange interviewing. While eleven of this initial cohort of thirty-seven subsequently declined to take part, twenty-six interviews were arranged and conducted.

Semi-Structured Interview

"If you want to know how people understand their world and their lives, why not talk with them?" (Kvale & Brinkman 2009, p. xvii)

Within the pragmatism guiding this research, the author recognised the usefulness of language and knowledge as coping mechanisms in a changing world and how conversation and social practice are the physical manifestations of these (Kvale & Brinkman 2009, p. 51). Qualitative data was collected using semi-structured interviews in which participants were encouraged to discuss their understandings and experiences of the world around them. This particular interview approach was selected as it provides for a degree of structure meaning a coherent and systematic interview format, as well as a level of standardisation across the overall interview process crucial to the insurance of validity and reliability of data. This level of structure is accompanied by an informal conversational style allowing a fluid interaction removed from the perhaps stifling formalities that may inhibit free expression of the participants' ideas, opinions and perceptions. With this informal setting established, greater opportunity exists for the development of some rapport between researcher and the interviewee and with that the progression of a conversational dynamic; free flowing, receptive and natural discussion. Within this conversational mode, probing, noted as an "invaluable tool for ensuring reliability of data" (Barriball & While 1994, p. 331) due to the potential it holds for the clarification of issues raised and the deeper and yet tactful examination of sensitive issues, can be employed on a more relaxed and less interrogatory level. Further, this combination of rapport and probing can also foster a relationship which negates the need for the

volunteering of socially desirable responses as the participant, if comfortable in the interview environment and content in its privacy and confidentiality, is encouraged to divulge their views in their rawest possible form, untainted by the constraints of social expectation and even political correctness (Fielding 2003, Rossman & Rallis 2003, Creswell & Plano Clark 2007, Dickson-Swift *et al.* 2007, Pitts & Miller-Day 2007).

See Appendix 5 for a list of the topics covered within the interview schedule.

Method of Questioning

A central aspect of this research is the method by which the questions were framed towards participants in both quantitative and qualitative aspects of the study. Mindful of the critiques of previous work expressed within the *Literature Review* chapter, most notably in relation to self-report data and associated issues of socially desirable responses therein, the author attempted to elucidate the entrenched, latent cultural aspects of stigma in relation to depression by providing study participants with a degree of separation from the views they express. Following the work of Glynn (1989), this was achieved through the consideration of the perceptions of others' opinions. Glynn suggests that often individuals are not well versed in the process of self-reflection or well-practiced in articulating their own views especially in relation to controversial topics (Glynn 1989). One may add a suggestion of hesitance on the part of the respondent who may feel obliged by social protocol to supply the politically correct or socially desirable response thus adding a concern about the validity of the answer relayed to the interviewer.

It was hoped that by removing the responsibility for the holding of the viewpoint from the respondent to the wider society, freed somewhat of the pressures of social desirability, the respondent may be prompted to disclose their full feelings in relation to the society they perceive around them. It was also hoped that the anonymous, faceless, and distanced nature of the questionnaire phase and the relatively brief and confidential encounter of the interview phase would also assist towards this goal.

Development of the Pilot

Quantitative Aspect

Given the significant and repeatedly stated reliability and validity scores achieved by the measures employed in this study in previous work, a brief pilot study was undertaken with the aim of ensuring that the questions included were understandable and made sense in a rural Irish setting, and that the questions devised by the author outside of the validated measures were understandable. This piloting process was achieved with the assistance of a cohort of friends, relatives and neighbours of the author, representing varying ages and genders, who were based in a rural setting, and also with the assistance of staff members in Irish Rural Link.

Qualitative Aspect

Significant concerns had been raised from the outset of the study in relation to the ability to recruit members of the general public in rural Ireland to take part in either aspect of the study. In particular, strong concern was held in relation to recruiting persons, without the availability of monetary incentives or the ability for reimbursement for expenses accrued by participation (fuel costs etc.), to take part in the interview process in which a substantial portion of an individual's day was required. Mindful of this concern and the threat this posed to the practical completion of the study, a decision was taken to conduct the pilot aspect of the qualitative phase concurrently with the main qualitative data collection phase in order to utilise every opportunity for data collection to its fullest extent. The author felt that this approach was important, prudent, and, given the use of some of the already validated questions which were employed in the quantitative phase as baseline questions within this qualitative phase, sufficient as the ultimate aim of this pilot was to ensure that the questions were understandable. This task was also assisted greatly by the semi-structured approach being implemented in which probing could be used by the interviewer in instances in which full comprehension was not achieved by the participant in the first instance. As such, then, the recordings taken of the initial interviews conducted were replayed and analysed in detail with the aim of deciphering instances in which, for example, greater clarity in terms of question delivery was required. Minor changes were implemented based upon the outcomes in subsequent interviews.

Lessons Learned

In relation to the quantitative phase, suggestions made against the front-loading of socio-demographic related questions due to a feeling of discomfort and overt inquisitiveness from the outset were heeded with some questions moved to the later stages of the survey. Also, questions devised by the author in relation to ascertaining the popularity of some suggested colloquial terms for depression were also curtailed. Overall, however, those involved with the pilot reported comfort with the instructions given on the questionnaire, the questions asked, the Likert-type responses sought, and the layout and usability of the online interface.

For the qualitative phase, as stated, the desired elucidation of meaning from a number of the validated questions posed in the initially completed quantitative aspect allowed a certain degree of confidence that the questions posed to participants would be both familiar and thus understandable. However, the pilot period did lead to a reordering of the questions asked to participants with the aim being to allow a longer lead-in to the more challenging questions in order to allow the participant to settle into the surroundings of the interview setting, and also into the social situation of being posed questions in a sustained manner. Through this, it was hoped participants would, as much as possible, experience a greater level of comfort and rapport with the interviewer while answering questions in the latter stages of the interview.

Field Administration of Data Collection

As outlined, quantitative and qualitative data was collected concurrently within a single data collection phase within a single four month period. The quantitative aspect was launched in January 2012 which facilitated both the completion of the quantitative scales outlined above, but also the capturing of expressions of interest for participation in the qualitative aspect of the study. Quantitative data was collected via the completion of a questionnaire survey hosted online using surveymonkey.com. Upon registering their interest to take part in the interview process, thirty-seven prospective participants were contacted immediately via email to acknowledge and thank them for their interest in the study, and to arrange a suitable time and place to meet to conduct the interview at the earliest convenience of the prospective participant. The study information documents (see Appendix 3 and 4) were attached to emails sent for the perusal of the participants.

Interviews were typically conducted within two-four weeks of the completion of the survey online/expression of interest.

Twenty-six interviews took place between March and May 2012 and were conducted in villages and towns in fourteen counties across the Republic of Ireland. As the author was not a fully qualified driver at the time, travel across the country was solely by way of public transport. While at times difficult, this factor had the benefit of reducing travel costs. A number of overnight stays were required where travel from Dublin to early morning interview meetings in southern and western counties was not feasible.

Interviews typically lasted approximately one hour in locations convenient for the participant. A number of interview participants suggested meeting in the foyers of small hotels located within larger towns with participants in a number of instances happy to travel distances to make the appointment. Though this aspect was not directly discussed with participants, a suspicion exists as to whether this desire to meet outside of one's local environment was due to any reasons associated with the lack of privacy which could be achieved in smaller villages or towns where the presence of the author would be notable. A number of meetings also took place in cafes in smaller towns, in the workplace of the participants, and some in community centre-type facilities.

Upon meeting with participants, the author thanked them again for their time, presented them with a hard copy of the study information documents, and reiterated some of the key points from same including the participants ability to opt out of the interview and the study entirely at any point, that they may refrain from answering any questions, and that they may obtain a copy of the interview transcript if they so wished. Attention was also drawn to the detail enclosed in the documents in particular the helplines and services available should they want to speak with a health care professional at any point following the interview. Participants were then asked to provide their written consent to take part in the interview and for the interview to be audio recorded.

Interview questions were framed with reference to those questions employed in the quantitative aspect of the study, with, in some instances, the participant's initial response recalled in order to assist in the framing of the question. However, as no data analysis was conducted prior to the completion of both data collection aspects, quantitative and

qualitative, and also as the quantitative data collection was ongoing while interviews were being conducted, reference was not made to statistically established trends within the quantitative data during the interview process.

As stated, interviews followed a semi-structured format which allowed the author to insert further probes into the questioning where appropriate while also permitting the participant to deviate from the course of the subject matter for a temporary period in order to articulate a point, features which assist in the creation of the desired informal and casual feeling of the interview. Upon approaching the end of the interview, the participants were given the option to return to any aspect of the interview if they wished to elaborate further or articulate in greater detail any particular views expressed. This facility was also used by the author if, upon reflection, greater clarity in relation to points made was required.

Following interview, each participant was contacted by email and thanked for their participation with, again, the study information document attached for their perusal and the option of raising any queries they may have in relation to the study also re-stated.

It had been originally intended that determination of the number of interviews to be conducted would be guided by the principle of 'data saturation' in which cognisance of thematic exhaustion and declining variability within the dataset over the course of an interview series guide the researcher's decision-making (Marshall 1996, Guest *et al.* 2006). The practical application of this ideal however, proved difficult. As it transpired, though initial expressions of interest in taking part in an interview were high, in spite of measures to maintain contact with prospective participants, for a variety of reasons, including instances in which prospective participants sent emails describing their current experience of a mental illness and thus their not feeling comfortable to take part at that time, interest did decline among some of this cohort. Mindful of this potential for fall-off in interest, every effort was made to conduct an interview with participants who had maintained an interest in doing so. While data saturation was reached, for a period, preoccupation with maintaining interview participants was a real concern.

As mentioned, data collection ceased in May 2012. Immediately following this, data transfer and cleaning commenced.

In keeping with ethical requirements discussed further below, all data is stored as per the guidelines of the Data Protection (Amendment) Act 2003.

Process of Data Analysis

Cognisant of the predominantly quantitative focus of the work conducted in relation stigma, social distance and social support in the context of depression reviewed within the *Literature Review* chapter, in particular that work conducted in Ireland, this study sought to address this imbalance by holding qualitative exploration as a central and defining characteristic. In keeping with this outlook, the analysis of data was completed while maintaining a qualitative gaze and, as discussed above, weighted towards the dominance of qualitative principles.

Following the instructional work of Creswell and Plano Clark (2007), the first stage of analysis comprised a separate initial analysis of each dataset comprising preparation, exploration, and analysis resulting in the furnishing of some preliminary results.

Qualitative Data Analysis

According to Creswell (2009), qualitative data analysis involves "preparing data for analysis, conducting different analyses, moving deeper and deeper into understanding the data... representing the data, and making an interpretation of the larger meaning of the data" (2009, p. 183). In the present study, analysis began upon the commencement of transcribing the interviews conducted using voice recognition software *'Dragon Naturally'*. This process involved listening to the audio recording of each interview conducted and repeating every word spoken into a microphone connected to the computer. The software then produced the interview data on a Microsoft Word document. While a laborious process, this offered an invaluable opportunity for immersion within the data, re-familiarising the author with the proceedings of the interviews and the crucial explicit detail, mood, and phraseology employed; key aspects which would have been missed had this task been outsourced. Upon its completion, the author had gained the desired further, deeper level of familiarity with the interview proceedings, an outcome which acted to create awareness of, and instigate thought processes in relation to, early trends within the data.

For management and facilitation of analysis of the qualitative data collected, Word documents containing the interview transcriptions were imported to NVivo version 9. Such qualitative data analysis software has gained in popularity in recent times due to the advantages it presents such as greater efficiency in terms of the more repetitive tasks involved, as well as improving the "quality, rigour and trustworthiness of the research" (Welsh 2002, p.5, as cited by Jones 2007).

The data was analysed using thematic analysis; "a method of identifying, analysing and reporting patterns within the data" (Braun & Clarke 2006, p.79). Endeavouring to remain true to the data gathered, the author adopted an inductive approach to the analysis with emphasis placed upon processing the data based upon its content as opposed to preconceived ideas of how the data should be coded. Noting the ethnographic approach adopted in which the emphasis is placed upon reaching the goal of exploring the tacit or implicit knowledge of the participant, the analysis moved from an initial, mainly descriptive "semantic or explicit level", towards a "latent or interpretative level". This direction assisted in achieving other key considerations of ethnography such as obtaining an insight of the insider's point of view and a deeper insight into the lives of participants. Based upon the constructionist perspective in which the study is partly set, the ideologies underlying the responses offered were identified and interrogated (Braun & Clarke 2006).

Thematic analysis involves six phases. Having completed phase one of this approach in which the researcher is instructed to familiarize themselves with the data via transcription, reading, and re-reading, phase two focused upon the systematic generation of initial codes. Within Nvivo, these initial codes were represented by a long list of nodes onto which relevant detail from each interview is attached. Phase three aims to "re-focus the analysis at the broader level of themes" (Braun & Clarke 2006, p. 89) via the collation of coded data within identified themes and was achieved through the analysis of the initially coded data with a central focus being a consideration of the relationships which exist between codes and how they may be combined in order to form a common theme. With candidate themes established, phase four emphasised reviewing and revising same in a two level process; reviewing data at the level of the newly established themes ensuring that they are coherent and applicable to the theme itself, while level two promotes consideration of the themes devised and whether they are reflective of the dataset on the whole. With this complete, phase five concerned a more decisive defining and naming of

themes with clarity a central concern. Lastly, phase six was the final opportunity for analysis and involved producing the report via the selection of extracts of the data which "capture the essence of the point" (Braun & Clarke 2006, p. 93) being demonstrated with a constant focus upon such extracts position within the wider story of the data.

Reliability & Validity

Following the suggested reliability procedures outlined by Gibbs (2007) as cited by Creswell (2009), conducting this systematic form of analysis and also the transcription process detailed assisted in establishing the reliability of the qualitative data collected by ensuring there is no drift in code definition or shift in code meaning, and the overall accuracy of the data collected, respectively (Creswell 2009, p. 190).

Validity in qualitative research is "based on determining whether the findings are accurate from the standpoint of the researcher, the participant, or the readers of an account" (Creswell 2009, p. 191). Creswell goes on the suggest several validity strategies a number of which are employed in this study including triangulation, rich and thick description, discrepant information, peer debriefing, accounting for bias, and use of an external auditor.

Taking each interview participant as a unique data source, consideration of each account rendered allows for triangulation of the data thus providing coherent justification for the themes established. In line with the qualitative focus of the present study, this strategy is supported by the adoption of a qualitative lens upon the consideration of the quantitative data yielded also.

Aimed at improving reader experience, the provision of thick descriptions and also of discrepant or contrasting views of findings also assists validity via their ability to provide context to the reader, and to credibly reflect the broad range of opinion participants hold, respectively. Peer debriefing was carried out with the assistance of the research supervisors who critically reviewed the content of interviews towards establishing its relevance to other readers, while external auditing was also conducted via the presentation of the material at a number of research conferences entry to which was by

review of study material by those external to the research process with feedback also received from independent delegates.

Lastly, bias is also considered. As outlined in the *'Study Limitations'* section below, while some bias may be possible due to the overall purposive sampling employed, that the interview data produced via implementation of the interview schedule and semi-structured design serve to address the research aims and objectives may be seen to offer credibility to the qualitative phase (Bryman 2008).

Quantitative Data Analysis

Survey data was downloaded from surveymonkey.com onto an Excel spreadsheet. The data was sorted and cleaned at this point and transferred to the Statistical Package for the Social Sciences (SPSS) version 19 at which point the data was cleaned further in order to ensure its accuracy. Similarly to the early analysis phase of the qualitative data, completing this preparatory work also facilitated a level of immersion within the data as an overview of responses was detectable. In considering the three levels of quantitative analysis (descriptive, correlative and experimental), deciding which level of analysis is required is dependent upon consideration of which level will appropriately answer the research question.

With reference to the Central Limit Theorem, the data collected was parametric. For the tests conducted the level of significance was set at alpha $< .05$.

Descriptive and inferential analysis of the dataset was undertaken. Descriptive analysis involved producing details in relation to the scales employed in the survey aspect and the compilation of socio-demographic details obtained in order to describe the main features of the dataset collected. Inferential analysis comprised the use of cross-tabulation and Pearson's chi square test. Cross-tabulation was conducted in order to gain an initial appreciation of interrelationships between variables in the dataset while also acting to highlight potential interactions of interest between such variables which may prompt further investigation. Where further enquiry was merited, hypotheses were configured and tested using chi square tests which sought to understand if a relationship did exist between such elements.

Data Integration

In the second stage of this analysis process both datasets were merged in order to create a "complete picture" of the overall data collected and, crucially, to comprehensively answer the research questions posed. From this process, the author came to understand the degree of convergence or divergence between the datasets, how and why these have occurred, and the similarities or differences which are evident within the different levels of analysis. This merging of quantitative and qualitative data was achieved through the process of data transformation in which, given the primacy of qualitative methodology, the quantitative data was qualified and is thus presented in an overtly qualitative manner in the following chapters. Pertinent quantitative or qualitative results are intermeshed, with outcomes from one method typically stated initially and then followed up where appropriate with aspects of the results of the alternate methods used (for example; specific quotes or statistical outcomes) in order to confirm or question the initial result stated and to substantiate same. The level of interconnectivity between the instruments employed within the quantitative aspect and the questioning within the semi-structured interviews may be seen to assist this integration and also the validity and reliability of the findings (Creswell & Plano Clark 2007, Creswell 2009).

Ethical Approval & Considerations

Ethical approval for conducting this study was sought from and granted by the Ethics Committee of the Health Sciences Faculty of the University of Dublin, Trinity College in May 2011.

Espousing a different study design, the author had previously applied for ethical approval but was not granted same. This triggered a critical reassessment, not necessarily of the study question or of the overall aims or objectives, but rather in relation to how the sample frame was to be engaged and the manner in which data was to be collected.

Ultimately, this period of critical reflection encouraged the adoption of the present innovative approach in which ICT is employed in order to engage with the 'hard to reach' rural population in a more ethically sensitive manner. This period also saw engagement, dialogue, and ultimate collaboration with a gatekeeper organisation, with the harnessing of

their resources and social capital to prove extremely useful in engaging with the desired target population.

With such changes to the proposed study design in place, a second submission was made. Key ethical considerations for this study included aspects relating to the initial engagement with the sample frame, conducting the research with study participants, and issues in relation to the management of the study following data collection.

Further to detail within *'Field Administration of Data Collection'* above, within the initial engagement with the sample frame via email, the provision of comprehensive information in relation to the study, its subject matter, how the research would be conducted, who was organising the study, and how they could be contacted was of vital importance in order to assure the prospective participants as to the legitimacy of the study. The author was cognisant that it was possible that vulnerable individuals may receive the study email and so measures to limit the potential upset which might be caused or any perceptions of duty to take part were included. Recipients of this information were also made explicitly aware of the voluntary nature of their prospective participation and of their right not to take part if they so wished. To achieve this end, detailed and yet uncomplicated information, reviewed by the ethics committee, was included within the initial communication with the sample frame and throughout all further contact with interested parties.

For both cohorts, it was of paramount importance that participants felt assured that their privacy was being maintained throughout the process and thereafter. Participants were given assurances as to the safety and privacy of the data they provided with guarantees of complete anonymity and of the protection of the data provided within the guidelines outlined by the Ethics Committee and in line with the data protection legislation.

In relation to the process of the dissemination of research findings, the abovementioned consideration of personal confidentiality is one aspect of risk that must be accounted for prior to submission for publication and can be done so upon rigorous observance of data collection, storage and reporting guidelines. However, outside of individual concerns it must be noted that potential risk also exists in this regard as findings produced may in themselves be of a negative or uncomplimentary nature in relation to both individuals and/or wider communities and thus have the potential to cause upset. Addressing this risk

requires again strict adherence to data reporting guidelines, and also an approach in which the author, while bound to remain true to the data and its analysis, reports in a manner which is emancipatory and solution-based. In this sense, where critique may be offered, while firstly it must be substantiated within the data, it must also be offered with great sensitivity to the population under discussion and as much as possible serve the purpose of advancing the discourse under discussion.

Personal Reflection

On a number of occasions the extent to which the issues being discussed had a significant and profound impact upon the lives of the participants involved became apparent to the author. Two particular examples which encapsulate this are presented below.

The author met with a young mother living in a rural part of the south west. Within the first few minutes of interview it became apparent through a reading of body language that the participant was uncomfortable but yet fully engaged with the interview; a mixture of smiles, eye contact, together with bodily swaying within the chair as if to avoid sight within a face-to-face interviewing scenario. The author was aware of the discomfort and thus took a relaxed stance in terms of questioning, leaving significant room for the participant to articulate her points. Soon, and without prompting, the participant revealed that she had herself experienced depression, had attempted to take her life, and had been admitted to a psychiatric hospital for treatment some years previously.

She spoke in detail about her experiences of depression, how it had manifest and impacted upon her life in terms of her relationships with her family, friends and colleagues, her eventual suicide attempt, and subsequent hospitalisation. The participant spoke about her experiences there, how her own ingrained perceptions of depression and mental hospitals served to make the suggested treatment difficult for her to accept, her preconceptions in terms of her loss of autonomy at this point, and also the level of discrimination which she received from some of those charged with her care. Further, she spoke about her reaction to the stigma which she perceived to be placed upon her at this time, the isolation which she forced upon herself in order to avoid contact with the wider community, as well as the experiences following her eventual emergence which, sadly, only served to justify the image of being a social pariah which had dominated her thoughts

to that point. The impacts of her experiences were enduring with the suggestion that many years after the event from which she has recovered, she felt tainted in the eyes of others due to her experience of depression.

A second instance of note among many throughout the interview phase occurred while interviewing a middle-aged, woman in the Munster region. The participant provided a full and frank interview articulating her views and challenging aspects suggested by the author which displayed a great interest in the subject matter. However, the most important aspect of the interview emerged just as the participant was advised that the interview was entering its final stages. As if wanting to be sure not to let the moment pass, the participant suddenly began to speak about her own life in greater detail, recounting her own experiences of depression. She spoke at length about how her elderly mother found the concept difficult to understand, how her brother dismissed her behaviour, and her reliance upon her sister to provide a warm embrace at such times. She also spoke about her fear of her condition emerging within her professional environment articulating a sense of terror at the prospect that knowledge of her own depression would emerge due to her understanding that isolation from important work developments and effective demotion would be a certain response.

Being the recipient of many such personal and often extremely difficult stories had a profound effect both on a personal level and also in terms of my role as the researcher. On a personal level, one cannot help but be impacted by the often traumatic stories recounted by individuals present before you who are recalling some of the most difficult moments of their lives to, essentially, a stranger with an audio recorder. I was acutely aware of how difficult the recounting of such immensely private events must have been for participants, the great bravery required in doing so, and, indeed, the significant level of trust being placed in me as the person, again, the stranger, to whom such personal and private details were being divulged. Interestingly, on more than one occasion, my position as this 'stranger' was suggested as being of significant benefit by participants who felt that, as I was unknown to them and/or others in their social network, that, as well as the broad assurances I had provided in terms of confidentiality, I posed even less risk in terms of their stories being repeated elsewhere which may have a detrimental impact upon them.

While difficult, there was a significant and unavoidable sense that this was on the whole a cathartic exercise for interviewees. Cathartic in two-ways; firstly in that the interview provided a platform for the interviewee to open up about their experiences in a more public manner than many had anticipated being able to do so. Secondly, one also felt from participants that their participation in this manner was, for them, an act of protest, a rebuff to the discrimination many of them had experienced, with their hope being, as was often uttered upon the conclusion of the interview, that if their words were in some way to help another experiencing the same in their lives it would be entirely worthwhile.

On a personal level, while of course empathetic, it was also pertinent not to become overly emotionally invested in the interviews and thus I attempted to approach and leave each interaction in a professional and emotionally distanced manner. I also took the opportunity to speak with my supervisors about the interviews and gained their support within this aspect of the study.

As a researcher, these personal responses served to motivate substantially. There is felt a duty in this paper to hold as central the views, opinions, and experiences articulated by those who took part in this research in order to effect a level of change within an area of social life which they so evidently care so much for. The participants have become stakeholders in this study to whom the researcher is beholden with the ultimate outcome of these extraordinary interactions being the provision of an impetus towards the completion of a high quality piece of research, matched in integrity with that of the participants who so altruistically shared their stories.

Summary

This chapter has presented a detailed account of the worldviews and research philosophies which shape this research together with detailed information in relation to the resultant mixed method research strategy employed to effectively conduct this work and the rationale for same. A comprehensive guide as to how such a strategy combining both quantitative and qualitative research methods and the adoption of online technologies was operationalized in order to meet the study objectives is also included together with details in relation to the analysis of the data yielded and its reliability and validity.

Chapter Five - The Stigmatisation of Depression

Introduction

The purpose of this chapter is to discuss the views of the study sample in relation to the stigmatisation of depression in rural Ireland. The chapter will begin by outlining the evidence which points to an acknowledgement that depression is frequently dismissed as a source of concern equal to other forms of illness, instead being broadly construed as a form of personal failing. Next, the chapter progresses to articulate the manifestation of discrimination associated with depression within varying social contexts. The chapter then moves to highlight the perceived role of fear within this stigmatisation followed by a suggestion that, owing to the aforementioned factors but also itself a significant discriminatory implement, a culture of secrecy has emerged in relation to depression in rural society which acts to stifle greater understanding.

In this and the subsequent two chapters, the themes presented are supported by anonymized extracts taken from interview transcripts (n=26) and also by selected relevant findings emerging from the analysis of the survey data (n=174). Of the survey respondents, 72% were female with the average age noted as 41.04 years (*SD*=12.50). Of the interview participants, 69% were female with the average age of those for whom such data is available noted as 42.87 years (*SD*=11.279). Further detail in relation to study participants is presented in Appendix One.

The Stigma of Depression

Upon a broad qualitatively driven consideration of both qualitative and quantitative data yielded, it is apparent that a considerable stigma is perceived to persist in relation to depression in rural society. Outlined as an othered human condition; an exception, depression has arrived upon a status of being set aside as different in the eyes of the community who are seen to perform an almost subconscious double-take of consideration and adjustment upon its encountering. This demarcation of difference is seen as the cornerstone upon which this stigma is constructed, establishing a form of rationale for subsequent differing treatment:

> 'People who have depression problems... are treated and looked upon differently than people with any other health problems or issues. That's my honest feeling on it. I would have liked to have thought differently on it, but I don't' (Female, 60, Interview 11).

> 'People look at you differently, I think they will look at you in a way in which "you have a problem"... I think it does change your perceptions of people' (Male, 40, Interview 22).

Maintaining that broad viewpoint, as predicted and following a similar trend to other studies discussed in the *'Literature Review'* chapter, the outcomes of the Depression Stigma Scales produce an overall image of sample members as personally holding relatively low levels of stigmatising attitudes while conversely viewing others as holding significantly more intolerant attitudes towards those with depression. The personal stigma scale (Cronbach's α = .73) reveals a relatively low mean level of personally held stigma towards depression of 6.89 (*SD* = 4.96) from a maximum score of 36. However, reflecting the poor light in which depression is perceived to be held by others in rural society, the perceived stigma scale (Cronbach's α = .86) holds a significantly higher mean of 20.70 (*SD*= 6.96).

The following sections provide further and more detailed insights in relation to the perceived relationship between those in rural communities and depression which individually, and even more powerfully when considered in concert, serve to support the perception of the stigmatisation of the condition in this setting.

The Dismissal of Depression

> 'Some people might feel sympathetic but a lot of people would say that "they just need a good kick up the hole" or "they just need to pull their socks up and get on with it"' (Female, 27, Interview 16).

Cognisant of Link and Phelan's (2001) noting of status loss as a component in the unfolding of stigma, results from the Depression Stigma Scales suggest that depression is not viewed to be treated with the same level of importance as may be expected for other mental or somatic conditions. Over half of survey respondents (55.8%) agreed with the statement suggesting that most others did not view depression as a real illness with 9.2% of respondents indicating they strongly believed this to be the case. Interestingly, 85.7% of those within the 65 years and over age category agreed that others would dismiss depression in this manner. The outcome for this item contrasted significantly with the

response to the same statement on the personal scale in which the overwhelming majority (95.4%) expressed their view that depression was indeed a real medical condition with 86.2% of those strongly disagreeing with the suggestion to the contrary. When presented with a statement suggesting that those experiencing depression could 'snap out of it if they wanted', while almost the entire sample (93.7%) stated their own personal opinions disagreeing with this contention, with 69% of those disagreeing strongly, 62.6% of respondents asserted their view that most others believe that one could indeed choose not to be depressed if they so wished. The majority of those who agreed in this instance agreed 'somewhat', however, 8.6% of the sample strongly agreed with this statement.

This perceived movement towards the near dismissal of depression as a condition meriting concern is repeated within the interview transcripts in which many participants acknowledged a level of flippancy towards the condition. Such glibness was often recalled within the context of the traditional value attached to "getting on" with one's life; progressing towards a somewhat predefined ideal of personal and social development:

> 'For those from a wealthy family or a well-to-do (family) it would be "well what have they got to be depressed about" but if, for example, the family weren't working, it would be "well why didn't they get up and get a job, they might feel better!"' (Female, 37, Interview 25)

> 'If you heard of somebody who is depressed people would tend to say "Jesus what are they to be depressed about? They have plenty of money and a nice house" and that kind of thing and that flippant kind of attitude towards it really. People would pass remarks like that definitely' (Female, 35, Interview 20).

In line with expectation, while acknowledging their existence, interview participants frequently sought to distance themselves from the narrow-minded or uninformed attitudes viewed to prevail in this setting:

> 'I am not saying that for me personally, but sometimes it can be... "Well she is able to go out there, and she is able to go to the pub and have a drink, and she is able to do this and that, and then she is complaining about being depressed?!", you know that kind of thing?' (Female, 59, Interview 12).

This dismissal may be seen as pointing to the lower ranking associated with depression and to a perceived lack of understanding of the condition and the restraints it places upon

self-efficacy. Further, such attitudes also reflect the level of importance attached to 'getting on' in one's life, with failure to do so attributed to a specific will not to above other considerations of personal circumstance or ability. This aspect is discussed in further detail within the *'Social Norms, Values and Expectations'* section in the following chapter.

In accordance with the trend of dismissing depression, a suggestion exists that owing to perceived lack of knowledge or education as to the aetiology of depression, others viewed it as a personal failing; the product or consequence of circumstances of one's own creation or the creation of one's family. The emphasis, then, is placed upon seeking an explanation of this outcome with an implicit understanding holding depression to be the outcome of questionable or deviant behaviours or intentions:

> '"Jesus where did it all go wrong for him?!" you know? And there has to be something, there has to be some incident or some trauma or you have to be able to point to something (that caused depression)... "how did this happen?"' (Female, 37, Interview 23).

> 'Nothing is nearly said of it nearly, it's been expected that his life would go like this because of the circumstances that have happened in his life you know. Never having a girlfriend, and never having gotten married, and was working in that factory that closed down, and if you listen to the family talking about him they will say (whispered) "he was always a little bit weird" you know' (Female, 42, Interview 8).

Highlighted later also within the discussion of *'The Use of Euphemisms'*, the idea of self-imposed depression was most often seen to focus upon alcoholism; with the formulation of this linkage and the content of this understood relationship of great interest. Detailed as an intrinsic aspect of rural and broader Irish culture, the consumption and at times abuse of alcohol may be seen to be conferred with a distinct level of social acceptability:

> 'I know people who were on the other side of the family who are alcoholics and would be quicker spoken about and acknowledged than maybe my great-grandmother who suffered from depression... because alcoholism is more out there, almost every family has someone somewhere that was fond of the bottle so it's more accepted' (Female, 37, Interview 25).

In common with the dismissal of depression, instead of viewing problem drinking as such, alcoholism was perceived to be seen almost as a choice and often labelled as over-indulgence, the result of a foolish, almost silly, but wilful lack of personal control. This

downgraded idea of addiction is suggested by some to make the circumstance less socially salient and, crucially, within the ability of the person to amend:

> 'I don't think anybody is going to say "oh that fella walking down the street has depression"... what they might do is say "well he suffers a bit from the drink", or "sure he has a weakness for the drink". That's the polite way of saying that he has something else wrong with him...' (Male, 40, Interview 22).

> 'If you're an adult male depressed in rural Ireland you're going to have an alcohol problem too. I would think that from what I see around the place that you are also probably an alcoholic like, and that gives people another word... it's more acceptable to be an alcoholic for whatever reason... "Did you see he's taken to the drink", and that's it...' (Male, 25, Interview 2).

The substitution of acknowledging alcoholism for depression may be seen as a strategy to both avoid social notability and dismiss the condition as a mere folly of one's own design.

The notion of self-imposed depression received some limited support within the survey data. The suggestion which encapsulated this idea, that most people viewed depression as attributable to unhealthy lifestyle choices, was supported by over one quarter of survey respondents (28.7%), with the majority in this instance (26.4%) supporting the contention in a reserved manner favouring to 'agree somewhat' with the provided statement. This outcome is in keeping with the suggestive nature of the discussions around this topic throughout the interview data in which this aspect was seen as one element within a wider set of influencing factors.

Depression as a Form of Weakness

> 'It (depression) would be seen as a weakness as opposed to a specific illness like cancer or something...' (Female, 61, Interview 10).

In line with the process of othering (Dunham *et al.* 2004), such thinking of self-imposition may also be seen to supplement an "us and them" mentality with those experiencing depression thought to be in possession of some extraordinary personality traits predisposing them to this wasting affliction, a destiny those without such traits will likely avoid:

> 'If you suffered a lot from depression you were seen to be a lunatic or that you weren't fitting into society, that you were a weak link or whatever. I don't think there is a full understanding that every family and every person is susceptible to depression... people don't want to see it like that, they just (don't), for whatever reason, and actually add to the problem by doing that, by not being understanding and by not having enough care' (Male, 54, Interview 24).

Cognisant of the view that broader rural society has effectively moved to declassify depression and place its experience within the realm of personal prerogative as opposed to a condition outside of one's control, it is unsurprising that survey respondents largely endorse a view that depression is seen by most others as a sign of personal weakness. Concurring with previous research in this vein (Coppens *et al.* 2013, Griffiths *et al.* 2006), 58% of the sample were in agreement with a statement to this effect. Interestingly, 92.5% of respondents outlined their personal rejection of this statement with 80.5% strongly opposed to such a contention. Also interestingly in terms of the discussion of gender presented below, a chi square test carried out to assess the null hypothesis that there is no association between gender and viewing depression as a form of weakness found that the null hypothesis could be rejected (X^2 = 12.893; df = 4; p = .012), this indicates strong evidence to support this association in the target population. The personal rejection of the provided statement was less forceful among male respondents with 67.3% stating their strong disapproval with the sentiment compared with 85.6% of females.

Supporting the finding that a large contingent of respondents perceived depression to be viewed as a weakness by others, and indeed more strongly than the survey responses may suggest, interview participants noted overwhelmingly that the condition is linked with a perception of diminished personal physical strength or capacity, and with reduced emotional resolve. Consequently, a person with depression was said to be viewed as somewhat maladjusted or under-developed with particular language, sayings and euphemisms (an aspect covered in greater detail below) used in order to circuitously articulate such views:

> '"He's not sound", "he's lacking", you know, "there is a want in that lad"... "He's not all there", so this is not a fully formed person; this person is missing something, "he has a few screws loose", all the terminology! It all points to the fact that we look at these people and we see that they are not fully there' (Female, 37, Interview 23).

> 'You have the derogatory statements like "you're mental", and nobody wants that... It's definitely seen as a weakness you know' (Male, 38, Interview 14).

Noting the above commentary on the dismissal of depression as self-imposed, this weakness of temperament was described to be perceived in terms of a personal affliction which has its roots not within the biological or psychological, but instead as the outcome of a personal or indeed familial failing. Noting this, participants often described a view of depression as a 'flaw' in the sense that it was a blemish upon one's person, personality, and image:

> 'It would be seen as a weakness for them wouldn't it, depression would have been seen as a weakness... a weakness like that it's kind of a flaw' (Female, 37, Interview 17).

> 'It (depression) is seen as a weakness, I can think generally it is seen as a flaw... Different people will have different perspectives on whether that is a self-inflicted flaw or is it a flaw you should be able to deal with yourself, or is this a flaw, you know, that is more like a birth defect as in something that is outside of your control but is still a flaw...' (Male, 61, Interview 9).

This association with weakness may be suggested to contribute to the survey finding in which a small majority of 47.4% agreed to some extent (35.1% chose to 'agree somewhat') that most others would not vote for a politician who had been known to have been depressed:

> 'People would ask whether they will be fit to handle the pressure I suppose; would they be psychologically strong enough to withstand the pressures or would they be too sensitive for it?... "Are they fit for it? It's a cruel world politics, are they fit for the barbs that is going to accompany it?"' (Female, 37, Interview 25).

Again this finding contrasts considerably with the stated personal views of survey respondents with 81% disagreeing with the notion that a candidate's history of depression may influence their decision of for whom to vote.

Depression as Disabling

> 'It manifests itself in an inability to work, in an inability to function in any matter' (Female, 60, Interview 11).

Together with ideas of weakness, it became apparent that the condition holds a significant association with possession of a disability which denies those afflicted full participation in society:

> 'For me, I suppose depression is somebody that is unable to get up out of bed and maybe do what they can or the day's work, or look after their family, that they end up crying or are very down in themselves or see no future for themselves' (Female, 59, Interview 12).

Depression was noted by participants to be perceived as a condition of significant consequence. As an indicator of associations with chronicity, it is interesting to note the frequency with which depression is discussed in the same context as cancer with comparisons frequently outlined associating aspects such as the severity of the condition, the disruption caused to the life of the sufferer and those who care for them, and the degree of disability it is deemed to bestow:

> 'To me it's just the exact same as an illness like a cancer, if you had a cancer you would get the top people to help you and people will be concerned and rally around you, but with depression there is this big stigma I feel in Ireland, people think you are crazy and they don't know what circumstances would lead you into depression' (Female, 41, Interview 18).

> 'It's a bit like the word cancer, depression is seen as a kind of a mental cancer that people don't like to label towards people, they will call it something else' (Male, 40, Interview 22).

Mindful of this, based upon their experience, many interview participants outlined an expectation of how experiencing the condition will be accompanied by a feeling of disability relative to those unaffected in combination with a view that one is not in a position to fulfil their societal duties.

> 'If I suffered from depression I would not feel that I would be as able-bodied as another person, that I wouldn't cope as well... Because everyone has a place in the community and you feel that you wouldn't be

> fulfilling your role as a citizen and then as a mother and a friend... I would have guilt...' (Female, 30, Interview 26).

A common concern held in relation to depression pertains to potential disempowerment where the views and/or actions of an individual are called into question on the basis of a perceived impairment of judgment. Participants noted a fear in which the integrity and autonomy of an individual could be undermined in this manner due to their assumption of the status of 'disabled':

> 'It's very easy to dismiss things on the basis of "oh sure you're just depressed" so what you're saying isn't valid. You know that we can discount your opinion on something because sure you're depressed and always grumpy, which isn't necessarily the case, (but) that's something that I've gotten quite a bit' (Female, 43, Interview 7).

> 'Someone that is suffering with depression can be seen as, if you're listening to people and rumours of stuff, they would say that they are "just looking for attention" and stuff like that' (Female, 30, Interview 26).

This disempowerment is seen as pervasive and understood in rural society and is suggested to be problematic to those experiencing depression who, it is suggested, may come to internalize such disablement thus further contributing to feelings of inadequacy and despair:

> 'I remember saying to him (brother with depression, deceased by suicide)... "would you not want to do one of those courses, you can go at night"... and I just remember the way that he looked at me; it was like "you think now that this is all I am fit for"... And I remember thinking that I shouldn't have said that to him... He was like "you are telling me to do this now because I'm like this...". So he even had that kind of a misconception about his illness' (Female, 37, Interview 23).

Workplace Discrimination

This aspect of disability was particularly mentioned in relation to one's professional life. Perhaps owing its frequent mention to the strong representation of employed individuals within the interview sample, interview participants described the experiencing of depression as an issue which, as well as being kept secret in local settings, would certainly not be disclosed within a current working environment or to a prospective employer. Such environments were viewed in the main as inhospitable in relation to the

potential provision of understanding regarding the condition with interview contributors suggesting that discretion in this regard would be a priority:

> 'I think workplaces could be different to family, people are more sympathetic with the family member rather than if it's a colleague' (Female, 37, Interview 17).

> 'Well, to be honest I suffer a bit myself and if I'm honest I would never tell my boss or my colleagues (and) there is another girl, one of my staff (with depression also) and I would never go to HR or management (about it) because it certainly wouldn't do you any favours... so I cover her ass a bit... It's a pity I can't just say "just leave her be this week..."' (Female, 43, Interview 7).

The underlying trend throughout those discussing depression in the workplace, again reverting to the recurring theme of depression denoting a form of weakness, relates to a perception that those experiencing depression are undesirable in the working environment due to perceptions relating to unreliability, a tendency towards absenteeism and, perhaps most importantly, a questioning of one's competency to fulfil an occupational role. Interview participants noted an understanding that employers are 'afraid of the hassle' (Male, 44, Interview 1) involved in the employment of someone with depression and were categorical in their belief that an admission of depression would severely damage one's opportunities for employment:

> 'People would be afraid to tell because it affects people going for jobs... if they are going for a job they will not tell people they have depression because if they do it would be a mark against them rather than a mark for them. There doesn't seem to be an understanding among employers you know that people that suffer from depression can still do a days work' (Female, 55, Interview 21).

> 'People would keep it (their depression) to themselves... I've seen it and heard it, I mean absolutely crazy stuff... Employers don't want to take a chance, they just say "this is a chance"... "I want the perfect employee, and anybody that has a potential weakness that could disrupt my (business)" that would be a negative against them' (Male, 61, Interview 9).

Evidence from the data suggests that caution towards disclosure in this regard may indeed be well founded as one participant, highlighting personal experiences, provided an insight

into interview board practices of some organizations which effectively dismiss those with mental illness outright:

> 'It's there in the back of people's minds all the time... we had interviews for (position) and the supervisor came out from (head office), a guy who was well paid with his 2010 car and should know better... and the first thing he says to me, "before you meet this one now, she is off the wall you know, she is into us all the time", and this was before she even walked in the door' (Male, 38, Interview 14).

For those already within employment, a disclosure of depression is deemed to hold significant repercussions for their continued employment. Some participants noted that upon disclosure, changes within the work dynamic are deemed forthcoming. Such alterations were typically seen as taking the form of effective demotion, perhaps not in title, but effectively through a reorganization, often directed from management, of one's work commitments or duties with the eventual goal being the completion of a less strenuous and, dependent on the work undertaken, often less public workload:

> 'There would be a bit of worry let's say (voice lowers to a whisper) if you have (people) that they have had mental breakdowns and that, that has happened, those people will be actively discouraged to have contact with the public again like and they will be given more desk jobs let's say as opposed to going out...' (Female, 61, Interview 10).

> 'We would have had a few people who would have been out of work due to depression yeah, eh, and would probably still be on medication and everything like... and you know you can see them that if the pressure comes on them in work-related stuff you can see them go, starting to go down again a bit sort of you know, and people would be aware of the pattern of when that might happen (voice lowers) and people would be afraid to put that bit of pressure on them to do an extra piece of work' (Female, 59, Interview 12).

Further to the perceived likely undermining of one's professional capacity within their current role, unsurprisingly interview participants also highlighted an understanding that such a disclosure may significantly damage one's prospects for promotion and career progression. Participants spoke of noticing a trend of passing over those with depression for promotion based upon that fact, or indeed related speculation, and the associated view which invariably questions one's ability to handle the pressures of the upward step. This may be seen as leading to the creation of a cycle of secrecy in this regard:

> 'It may not be in diseases like cancer or it may not be for a physical disease, but they will be saying "maybe we should not give him the job because you know he had a problem there a year or two ago". It may not be said out loud at meetings but you know straight away' (Male, 40, Interview 22).

> 'If you are very driven at work it would be kind of hard to say "I am suffering depression" because you might get knocked back or someone else might get promoted ahead of you or something like that... I personally would not tell anybody' (Female, 30, Interview 26).

Finally, and further to the threats of effective demotion and confinement to a static level of career progression, a disclosure of depression was also mentioned by a small number of interview participants as potentially leading to temporary or permanent dismissal from employment. Whether this may legally come to pass is debatable, however, the data shows evidence that a fear of such an eventuality occurring is present and, mindful of the suggested consequences of such a disclosure detailed above, within the realms of rationality to believe:

> 'I know one girl alone who was suffering from depression and she said, "I told you but please don't tell anybody else or I might lose my job"... she would be afraid that she would lose her job because they would call her crazy... she is afraid that if her boss heard that she was on antidepressants that he would sack her!' (Female, 41, Interview 18).

> 'They don't want people to know, and for people who are employed at the moment, particularly women, and I would be a working mother, and I feel that if I showed signs of depression that I might be forced to take a few weeks off or something like that...' (Female, 30, Interview 26).

From the survey data, in which respondents were asked whether they believed that most others, when placed in the hypothetical situation of being a recruiting employer, would refrain from employing someone they know to have experienced depression, just over half of respondents (53.8%) agreed with the sentiment. However, the agreement with which the statement is greeted is not definitive as the majority (42%) stated that they 'somewhat agreed' with the sentiment as opposed to the expression of absolute agreement.

Social Distance

> 'People always want to distance themselves from the unknown...' (Male, 61, Interview 9).

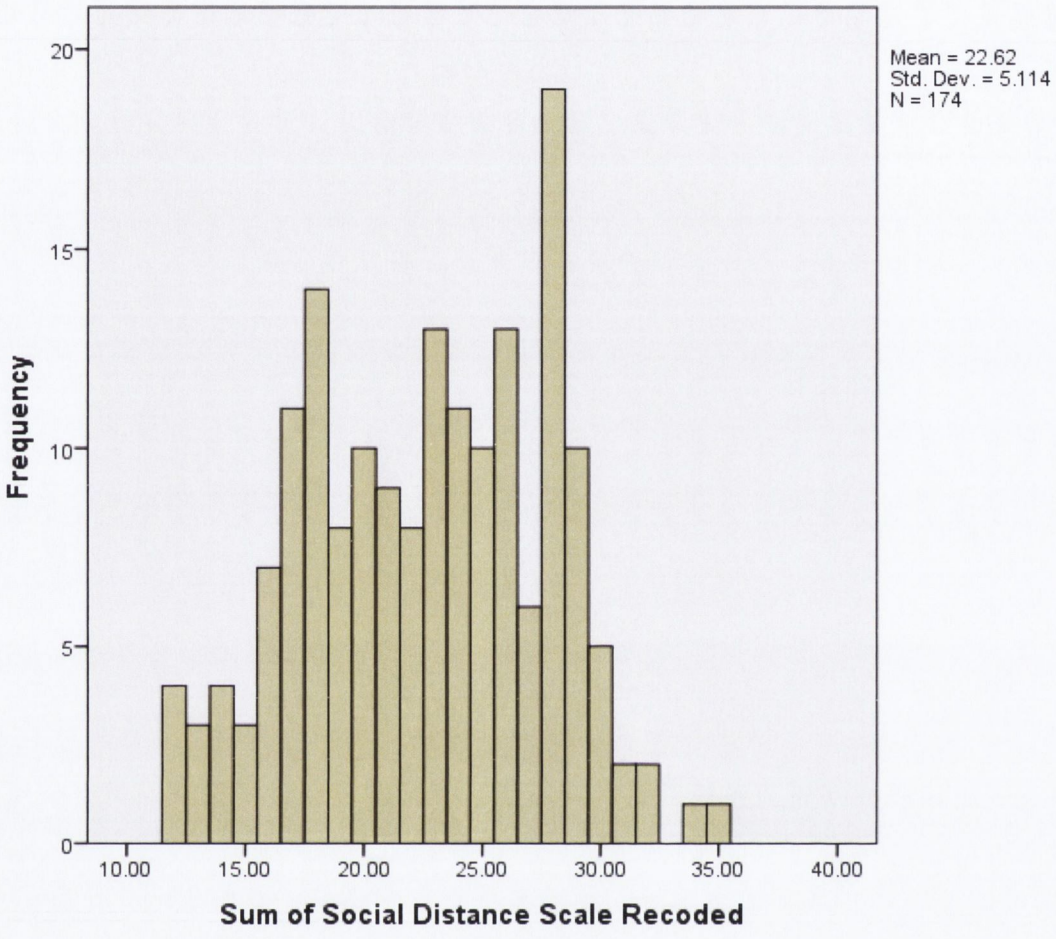
Considering the suggested movement towards homophily in social network formation (McPherson *et al.* 2001), further to the sentiments of exclusion which pervade in the above discussion of workplace discrimination, the data suggests that exclusion in broader society is perceived as a significant aspect of experiencing depression in rural communities.

> 'Weaker members of the group will all be picked on and its sort of part of genetic selection if you like; where to perpetuate the species you are selecting from the strongest members... when these type of people are a threat to the human race almost and as a subconscious thing you want to push them aside and that they shouldn't be part of the world going on you know. Maybe that's why it happens you know' (Male, 54, Interview 24).

> 'You sometimes feel that there are parts of society that don't tolerate infirmity of any type you know and just mock it or just remove themselves from it but certainly don't want to engage with it' (Male, 61, Interview 9).

As highlighted in the *'Theoretical Concepts'* and *'Literature Review'* chapters above, the concept of social distance has been used to great effect in order to supplement research findings relating to the uncovering of stigmatisation in relation to many social issues. In the present study a modified version of the Social Distance Scale (Cronbach's α = .82) was included as part of the survey questionnaire. From a potential maximum score of 35, the average perceived social distance score of respondents within the present sample is noted as 22.62 (*SD*= 5.11) with a slightly lower median of 23. The modal value of the sample in this regard is 28 (see Figure 2).

Figure 2: Sum of Perceived Social Distance scale



This outcome suggests the existence of an opinion among the present sample that others in society maintain considerable desires for social distance from those experiencing depression. In agreement with other studies in which this scale was implemented, a trend centring upon the intensity or intimacy of the suggested social interaction is evident. In a number of the relatively low intensity suggestions, such as questioning whether others might experience difficulty or discomfort in working beside someone with depression, to which a slight majority of the sample (40.8%) felt that others would be comfortable, or recommending someone with depression for a job, to which a relatively small majority (45.7%) felt that others would not be comfortable to do, the outcomes were relatively modest. However, upon increasing the intensity of hypothetical relations described within the given statements, the level of the perceived reluctance of others to engage rose considerably. This trend is particularly evident upon consideration of the statements which

questioned whether most others would be comfortable for an individual with depression to marry their child, and for such an individual to provide care to their child with large majorities of 77.6% and 76.4% respectively disagreeing to some extent with statements suggesting that others would be comfortable with these hypothetical social scenarios.

> 'That (stigma) is probably still there... there seems to be conditions on it, like "I am fine with this, but if my son wants to marry a girl who suffers badly with depression I would kind of be advising him against it"' (Female, 37, Interview 23).

Further to the abovementioned observed outcomes from the Social Distance Scale in relation to the reluctance perceived to exist in rural society to the proposition of an individual with depression joining a family through marriage, some interview participants articulated their experience of these sentiments outlining family interventions in order to maintain familial social distance from depression:

> 'If they (parents) have a farm of land and its 150 acres and if they have a son... who is dating this girl (with depression) and likely (to marry)... they would put a stop or try and end that kind of relationship... (It's) stigmatising the thing again, and it doesn't matter if she has one leg you know what I mean, or scars, or tattoos, but if she happened to (have depression (said under breath))... she wouldn't be seen as a suitable suitor ' (Female, 60, Interview 11).

> 'Bringing somebody with that kind of situation into a family... they (parents) will be concerned about how might this manifest itself? What might it mean for the future relationship? What might it mean for your family member? What might it mean for the children? You know, I think all of that kind of stuff would definitely be there... maybe more in rural areas that concern, maybe to do with property and farms... people don't want people to be getting involved with people with (depression), I mean they want the perfect' (Male, 61, Interview 9).

Further discussion in relation to the element of social distancing pertaining to the care of children is presented within the commentary on *'The Role of Murder-Suicide'* below.

Avoidance

> 'Country people, like they recognise this (depression) and they definitely wouldn't like to have it themselves and they would be wary of contact with it' (Female, 61, Interview 10)

The findings in relation to social distancing are supplemented by a considerable mention of the avoidance of those with depression in the community. As is common throughout the interview data, references to the traditional ways of thinking and acting which emanate from the past weigh heavily in participants formulations of their responses with reference to the uneasy relationship with general issues of mental health from previous generations featuring. In relation to the avoidance of persons with depression in the community, the past, typically discussed in broad reference to the latter part of the 20th century, is presented as a time of significant intolerance with suggestions that 'people ten years ago would have walked the other side of the road' (Male, 44, Interview 1) in order to avoid an encounter with such an individual known locally. Encouragingly, the data suggests that this somewhat extreme action is perceived as less likely to be repeated presently, however, a certain coolness of relations based upon an underlying cognisance of difference is acknowledged:

> 'People just don't generally want to engage with somebody who has a mental illness you know, because it's just safer not to do it. "Let them on..." That kind of thing. "I hope they are alright but I'm not really too interested..."' (Female, 37, Interview 23).

> 'They would not get into, they would keep it casual but then maybe that's the Irish way too you know, you know we are known for friendliness but it's very much on the surface really isn't it you know, as opposed to being deep down. Even we'll say in general conversation...' (Female, 61, Interview 10).

The data suggests that the perceived desires for social distance and the concomitant avoidance of those experiencing depression is, to a considerable extent, due to a multifaceted sense of fear in relation to depression in rural society. This aspect is discussed next.

Summary of 'The Stigma of Depression'

'The Stigma of Depression' sought to provide and introductive description of the manner in which study participants perceived depression to hold a stigmatized position within rural Irish society. Study participants gave details which suggest that depression is often dismissed, is seen by some as self-imposed, and by many as a sign of a personal weakness, thus suggesting the considerable undermining of the status of the condition and those affected by it. Evidence is presented to suggest the perception of a wider cultural view of depression as disabling and, as a consequence of this and other factors, likely to be a source of exclusionary practices. This finding was further supported by evidence in which study participants perceived a widespread societal desire for social distancing from, and the avoidance of those experiencing depression.

Fear

Fear is a consistent and dominant theme throughout the present research. From the data collected it became readily apparent that depression is not viewed by either the participants or, in their view, by others in rural society, in a comfortable and/or what may be considered normal manner as would be reckonable with the majority of somatic health concerns. Instead, perhaps the most pervasive themes which emerge in this regard pertain to feelings of trepidation and distrust. Operating at a variety of levels ranging from fear and suspicion in relation to a perceived physical and/or emotional threat posed by someone with depression, to a wider dread of depression due to the negative connotations it implies in the wider social environment, one may suggest the existence of a cultural understanding of how depression is understood to be perceived in society:

> 'It's fear. People fear. Fear that they don't understand it. Fear that it is contagious... they would be thinking "God I don't want to get that off them", you know, "I don't want to have a child with them in case they pass it on" you know? So there is that type of fear. And then for the person suffering with depression there is the fear of being ostracised, and... that would be a legitimate fear, definitely!' (Female, 30, Interview 26).

This overriding fear is discussed in two sections below; *'Fear of Physical Threat'* and *'Fear of Emotional Threat'*.

Fear of Physical Threat

'Fear of Physical Threat' refers to the insinuations within both datasets suggesting those with depression are perceived to pose a risk to the physical wellbeing of others:

> 'People are just nervous... in two ways; one - they don't really know how to deal with that person or how to respond to that, and the second one is for some people they would think that people with depression could lead to violent behaviour or other forms of threatening behaviour... you kind of don't really want to be in around that... So there is a kind of distance thing that happens because of that, those kind of fears' (Male, 61, Interview 9).

Supplementing to an extent the work of Link *et al.* (1999) and Jorm *et al.* (2012), within the survey data variation from the broad trend in which the personal views of respondents were overwhelmingly based within opinions of tolerance and equality appears in the instance in which respondents are asked whether they personally believe persons experiencing depression are dangerous. Breaking with the trend, while overall the majority of respondents strongly disagree with the statement, the comfort with which this motion is passed is relatively less than in other questions with 82.2% disagreeing in some form but a relatively small contingent (60.9%) of respondents voicing strong disagreement. Of those who were not strongly opposed to the statement, just over one-fifth chose to 'disagree somewhat' with the statement while equal numbers (8.6%) chose to remain neutral or undecided on the issue and detail that they somewhat agreed with the contention. This level of variation is absent on issues raised elsewhere in the survey. When respondents were asked to indicate whether they understood that most people were likely to view those experiencing depression as dangerous, just over half (54%) of respondents did not disagree with the statement expressing these sentiments. Just more than one-fifth (21.3%) chose to remain neutral on the issue while 32.7% agreed with the statement to varying degrees (agree somewhat= 27%, agree strongly= 5.7%) suggesting a view that, in the minds of the sample, most others to an extent perceived those with depression as dangerous.

These findings support strong endorsements of suggestions of perceptions of danger in relation to depression across rural society emerging from the interview data presented in the following sections entitled *'Unpredictability'* and *'The Role of Murder-Suicide'*.

Unpredictability

Further to the centrality of the desire for predictability of social life for efficient and effective navigation within the social environment as described within symbolic interactionism, the supposed unpredictability of those experiencing depression is perceived to evoke feelings of significant discomfort among those within rural communities:

> 'They might be more viewed as unpredictable, because there would be a view that "if they are not well at the moment" then you don't know what they're going to say, or are they about to lash out at you, or are they going to be okay with you... what reception are going to receive?' (Female, 37, Interview 17).

Participants described a potential relationship with a person with depression as fraught, with the opportunity of genuine interaction limited by a 'treading on eggshells... "don't mention the war" kind of thing' (Female, 61, Interview 10) forming a precondition where one must exercise caution in terms of conversation as 'you wouldn't want to be unsettling them either like' (Female, 35, Interview 20). Seen to be removed of the power of being in control of circumstances, the view of those with depression is one of continually teetering on the brink of control, thus eliciting a concerned response by those whose own sense of control of their own environment is being compromised:

> 'People wouldn't really feel that they know what's coming next... very unpredictable, and people don't like that then. Like there are so many different occasions where you would have heard people like that; "oh I wouldn't go near that one!"' (Male, 38, Interview 14).

The need for assurance of the stability of the person whose mental state has been called into question permeates throughout the responses. Discussed further below, special reference is made of the need, frequently above notions of self-preservation, to protect the vulnerable within one's care from the potential negative outcomes of interaction with a person with depression:

> 'Is this a stable person? With say a person that maybe wanted the child looked after, I suppose it would be ringing in their minds: "could this fella or this one go off the rails again?"' (Male, 54, Interview 24).

The viewed outcome, then, of breaching the lines of control is, interestingly, most often directly related by interview participants as an anticipation of a movement towards violence

in the first instance. A common depiction of an almost frenzied attack is suggested as a likely outcome with little questioning of the capacity or capability for the target to carry out such actions:

> 'There is a lot of stigma around the unpredictability of people and depression you know, and then people using the wrong terminology like "psycho" or "schizo" or things like that and linking that in the depression... people are making that in their brains and they are saying "well I don't want any 'psycho schizo' person sitting beside me, they could flip any minute!"' (Female, 30, Interview 26).

> '...there would be a view that if they are not well at the moment then you don't know what they're going to say or if they might lash out at you' (Female, 37, Interview 17).

Cognisant of the above mentioned survey findings in relation to the perceived reluctance of others to hypothetically place their child within the care of an individual with depression, a number of interview participants substantiated these outcomes. It was suggested that others would conduct an in-depth evaluation of a child care arrangement in which an individual known to experience depression was involved with some participants also airing their own personal concerns in this regard:

> 'They might have uncertainty to say if that person was suitable to look after your child... Would they do them any harm?... Would the person be stable enough if they were suffering from depression to look after a child?, "I don't know if I would trust her now to look after my child?!"... I would think that on a one-to-one basis people will be a little bit wary' (Female, 59, Interview 12).

> 'I don't think people would distance themselves unless there was an incident, unless that person got aggravated or aggressive, unless something happened I don't think people would really discriminate against people. Now in saying that I wouldn't like someone to babysit for me who was suffering from depression, and I'm sure that that is discrimination as they are just as well able to do the job...' (Female, 30, Interview 26).

Survey data supports the above articulated views of interview participants. The question in which respondents were asked whether they personally felt 'people with depression are unpredictable' also marked a significant change in the trend towards the personal disagreement with the supplied statements as 36.8% of the sample, the highest proportion

in this instance, replied that they 'somewhat agreed' with the statement with a further 1.7% being more forthright in this regard. Of the remaining responses, 11.5% chose to remain neutral on the issue as the outstanding 50% of responses were divided equally between those who disagreed somewhat and more strongly with the contention.

In relation to the perception of unpredictability held by others in this regard, unsurprisingly and in keeping with the trend, 61.4% of respondents stated their view that others in the community would view those experiencing depression as unpredictable with 10.3% stating that they strongly agreed with the statement suggesting this.

The Role of Murder-Suicide

A number of interview participants highlighted how their willingness and, they perceived, the willingness of others to extend their trust and close the social distance desired is influenced by their concerns in relation to the psychological and emotional stability of those experiencing depression. In particular, and further to the persistent discussion of suicide elsewhere throughout the interview process, mention was made to a concern about the likelihood of an individual moving to take their own lives and, through acts of violence, also inflicting injury or death on others in the process. Often citing instances in which such tragic events had occurred across the country and especially in rural areas in recent years, participants suggested that others held a considerable fear of persons experiencing depression due to the association with suicidal tendencies and an associated potential threat to the lives of others. This fear appears to have particular resonance due to the implication of children within the recent cases of filicide mentioned by participants with the intimation that the inclusion of such vulnerable individuals within such acts adds to the gravity of the situation and to the difficulty in understanding such behaviour:

> 'There have been some very high profile cases in the media over the last number of years of people with depression who have tragically murdered children... a very well educated colleague, whose wife suffers from depression and was in hospital recovering after attempted suicide, he took out a barring order against her when she came home from hospital... his concern was "look what has happened other people's children!"' (Female, 60, Interview 11).

> 'This is not my view now, but maybe because you have seen cases of people with depression... where mothers, because the help wasn't there,

> that they committed suicide and children have been killed in the process that perhaps people might think that there is an association...' (Female, 27, Interview 16).

> 'It is a concern because if someone was having problems, you've seen people doing really silly things... Like that man who committed suicide with the wife, Jesus Christ, unless you are an evil bad bastard you would have to have something wrong with you... there is a level of concern, you know, I don't have concern about my own kids you know (participant mentioned own depression earlier), but I think you would be dishonest if you said that there wasn't a bit of concern' (Male, 44, Interview 1).

Such occurrences may be seen as serving to legitimise both social distance desires and the stigmatisation of the cohort as perceptions of threat collide with primary needs of self-preservation and the protection of vulnerable dependents.

Fear of Emotional Threat

Further to the perceived potential threat of physical violence, the data also reveals a perceived emotional threat to oneself or indeed to the person with depression themselves as holding the propensity for the inducement of fear among the community. This fear is differentiated from its physical counterpart primarily by what can be understood as an element of concern for the person with depression, an element that appeared absent from the preceding discussion in which self-protection and the protection of the vulnerable or dependent were to the fore. While self-preservation is also a feature in this instance, this theme is distinguished by the inclusion and interlinking of other notably supportive elements. *'Fear of Emotional Threat'* is divided into two sub-sections; *'Bringing You Down with Them'*, and *'Fear of Interaction'*.

'Bringing You Down with Them'

'Bringing You Down with Them' pertains to the expressed fear that by extending a hand of friendship, or even merely engaging socially with a person with depression, one was effectively adopting the role of 'amateur psychologist' (Female, 61, Interview 10). Within this view, the depressed person would be viewed as likely to use such a connection as an opportunity to unload their troubles and concerns, a relationship which may, it is viewed, thus make the recipient of this information vulnerable to experiencing depression themselves. Sufficient mention is made of a preference to avoid a scenario which involved

interaction with a neighbour with depression so as not to burden oneself with their problems or potentially leave oneself exposed to becoming a source of reliance:

> 'I don't think people will go too far in rural areas but I think they will just pass themselves without getting too deep or too involved. They will have a feeling that "ah sure you're better off not getting too involved with someone like that", that you would be bringing a lot of hardship on yourself, that they would be expecting a lot off you' (Male, 54, Interview 24).

> 'It (limited interaction) is a small bit of protection, people are protecting themselves and not wanting to be taking on the burdens of others, or again maybe like myself, that they don't think they can do anything for the person and don't want to exaggerate a problem' (Female, 61, Interview 10).

A pathogenic realisation of depression in which explicitly stated views that depression was perceived by others as contagious, while rare, were present within the interview data. Imposing infectious characteristics, a fear was expressed for the potential that depression could 'rub off' on those in the vicinity of a depressed person. Suggesting a view of emotional vulnerability among others, many interview participants created a direct linkage between providing emotional support and the compromising of one's own mental wellbeing as a result of exposure to possibly difficult and challenging feelings and emotions:

> 'It can be a fear as well that if you allow yourself to get too close to somebody with depression, that are you not going to keep your own boundaries so that you don't get sucked into it yourself as well' (Female, 37, Interview 17).

> 'It's a bit like "I'm not going to stop and put all my energies into that person because maybe I will end up with depression or they will drive me down with them"' (Female, 59, Interview 12).

> 'My in-laws weren't very keen when they found out that I had postnatal depression, they said to my husband... "bring them (children) over to us now and we will mind them, and you come back over here, she's not right in her head, she is not a good influence on the kids, we don't want them developing this themselves, we don't want them developing these traits"' (Female, 37, Interview 19).

This sentiment is supported within the survey data where respondents were asked both whether they personally, and also whether they felt that most people believe that it is best

to avoid someone with depression so you don't become depressed yourself. While 86% of respondents personally rejected this statement, with 72.4% expressing strong disagreement, almost half of the sample (46%) agreed to some extent that others view depression as holding qualities of contagion and would thus alter their level of interaction accordingly.

Fear of Interaction

Centred upon an acceptance of the demarcation of those with depression as different from others thus meriting a differing approach to interaction, interview participants spoke of their perception of the existence of a fear of engaging in interaction with someone experiencing depression among those in rural society due to an uncertainty as to the correct social protocol to follow:

> 'It's the perception, they don't know what to say, they don't know what to do, didn't know whether to send a get well soon card or not. Do you send a get well card to someone who is we'll say, God forgive me, a lunatic?... I mean, what do you do?!' (Male, 61, Interview 4).

> 'It's just ignorance and lack of information and they may not know how to interact with a person you know. Like if you have a sore leg you can obviously see you have a sore leg and you can say "is your leg okay? What happened to it?" But with depression nobody knows because is not an obviously illness' (Female, 41, Interview 18).

Participants commonly held a view that others choose to disassociate themselves from those experiencing depression due to a lack of surety as to the correct way to interact with someone experiencing the condition. Again with an implicit undercurrent of accepted difference in which differing social rules of engagement are required, being unsure as to the correct manner in which to interact presented the potential for uncomfortable encounters:

> 'I wouldn't say it is deliberate, you see discrimination to me is when somebody sets out to exclude somebody... but I think it's the (lack of) awareness that really, I don't think they deliberately decided to discriminate against depression, I think it's just being uncomfortable dealing with this...' (Female, 60, Interview 11).

> 'For a lot of people the difficulty is knowing what to do... people don't know, it's almost like in terms of bereavements we are just not sure how to behave. I mean do you say "sure how is the auld depression

> anyway?" And I mean people don't really know what you can say, can you say "how are things? How are you feeling?"' (Male, 61, Interview 9).

With the demarcation of difference, this fear is seen to present potential emotional threats to both prospective interactants. For the person hypothetically initiating interaction, a fear of immense social discomfort and awkwardness is said to exist resulting in the felt need to overcompensate in terms of politeness and cordiality in conversation with the individual in question. This fear is triggered by a weight of expectation that whatever course of conversation is embarked upon, an over- or under-analysis of conversation content will ultimately lead to embarrassment. Seeking to avoid such an outcome, this fear is then viewed to manifest in a reluctance to actively engage with the person with the condition:

> 'I would have felt myself at the time (of experiencing depression) that people would have avoided me because they just don't know what to say... because what do you say when you meet someone (with depression)? "How are you?", which is a stupid question (laughs out loud), "and how are you getting on with your?"... People just don't know what to say at all... that is one thing that people should be told about; that just because someone is depressed it doesn't mean that you can't have a conversation with them... they are afraid for themselves, honestly afraid that they will say something that mightn't be nice' (Female, 33, Interview 13).

Interview participants felt that a similar emotional threat was deemed to exist for the person with depression also as they expressed a consideration that such an interaction, loaded as it was with indecision and anxiety towards the desired completion of a smooth conversation, may prove equally or more embarrassing and uncomfortable for those being engaged with:

> 'I would be like "so how are you?" And you know you would be afraid then "did I offend her by saying that?"... I would be like "God what do I say now?!" (in a panicked tone) And everything you say, you would be saying that again and wondering if she (friend with depression) was going to be offended by that' (Female, 30, Interview 26).

Leading on from this anxiety in anticipation of discomfort in prospective interaction, as alluded to earlier, a fear of unsettling a person with depression, a more serious level of potential emotional threat, is also suggested to persist. As outlined, those experiencing depression were frequently identified as possessing an inability to cope with aspects of typical lived experience. Consequently, it was felt to be incumbent upon others to attempt

to limit exposure to potentially distressing circumstances out of concern for the potential consequences of exceeding their coping capabilities. In combination with, and as a result of this, participants noted that others maintain a fear of behaving incorrectly in such situations as they find themselves in an uncomfortable state of uncertainty and ignorance. Participants suggested a resulting propensity for others to shy away from interaction or make special accommodations in order to avoid placing strain upon the perceived limited personal resources of an individual experiencing depression:

> 'Fear, its fearfulness... They are afraid to talk to the person just in case they feel they might say the wrong thing... That they might possibly upset the person (and)... trigger what I would call "an episode", but I mean they wouldn't know what an episode was...' (Male, 61, Interview 4).

> 'They just don't want to be there because just in case they did something stupid... And then there are people in the middle sort of who would not want to, to do any harm... They will be afraid that if they said something they would give the wrong advice, "if this happens what will I say"... They'll be afraid to say the wrong thing which would be worse than just leaving it as it is' (Male, 44, Interview 1).

Ultimately, one may suggest that this fear is grounded within the overriding desire to avoid being in some way responsible for the deterioration of an individual's depression or, in the extreme outcome, for a person's death by suicide:

> 'Fear of doing the wrong thing and of driving somebody to suicide, I mean that's a real fear... "I'll say the wrong thing and make them go off and commit suicide", and while this may have been a misunderstanding of the way things work you know, when you don't know you fear it and it is that fear of, of being responsible for something bad happening...' (Male, 61, Interview 9).

This fear of unsettling may be noted as not entirely selfless. In discussing an expressed priority among others to 'do no harm' (Male, 44, Interview 1) an implied perception that potential interactants may be astutely avoiding any potential feelings of guilt, embarrassment, or concern which may arise personally as a consequence of a difficult social interaction with those deemed as overtly fragile is detectable. This objective is seen to be achieved by maintaining a distance.

Importantly, the extent of the condition appears a significant factor in determining the avoidance of and/or distancing from those with depression in rural communities. Evoking the Goffmanian notion of local biographies in which a collage of past personal and familial exploits is assembled to create a social biography of an individual, one's behaviour or the presentation of one's self over time, often linked to one's condition, is deemed as important in determining the level of potential avoidance in rural communities:

> 'It's when somebody is known that they had a drop, that's when people start to treat them differently. Whereas if people can keep it going - it's terrible in a way because you're trying to bring more to the surface to deal with it, but in fact I think it's actually, it works negatively once it is known' (Female, 60, Interview 11).

> 'If they have done something we'll say like Joe Bloggs who was sitting in the middle of the village and ranting and raving, people will just shy away from it, whereas if you were somebody that was just minding their own business, or it wasn't their fault sort of thing, people would work away with you' (Male, 38, Interview 14).

Summary of 'Fear'

'Fear' detailed the feelings of trepidation in relation to depression which study participants expressed as being endemic within rural communities. This significant concern for one's welfare and the welfare of others in response to a perceived threat posed by an individual experiencing depression manifests in two ways. Firstly, a fear for the preservation of physical wellbeing with the supposed unpredictability and unstable mentality of the individual of core concern. This concern has been seen to be heightened by highly publicised recent tragic instances of murder-suicide; harrowing events which have left an indelible mark upon the mindset of rural Ireland and certainly coloured the popular conception of depression and broader mental illness. The second fear relates to a perceived emotional threat posed by those experiencing depression which culminates in a fear that interaction with such an individual may serve to dampen one's own mood as one takes on the troubles of the individual who is perceived as keen to offload them. Further, study participants noted their perception that others would feel great discomfort in associating with such an individual, would be unsure of what merits appropriate conversation, and would hold a residual fear of unsettling the individual and thus causing upset with the possible consequence of violence upon the individual in question or others in their vicinity.

Culture of Secrecy

> 'If you asked anybody about depression the first thing they would say is "why do you want to know that?!" So there is a great secretiveness or protectiveness around it and you know it's quite peculiar' (Female, 30, Interview 26).

In a two-way process the genesis of which is unclear, the stigmatisation of depression within this rural Irish setting may be seen to have led to the creation of, while also being itself continually reproduced by, a culture of secrecy. One may argue that this culture has historically acted, and continues to act to reproduce such stigmatisation predominantly through the stifling of the opportunities which may present to possibly challenge the dominant perceptions of depression, thus allowing the unopposed proliferation of stigmatising opinions and behaviours and the maintenance of the status quo.

The suppression of discussion in relation to depression has led to the consequential bastardisation of this discourse in order to facilitate its fitting within a mould of almost covert gossip whose own characteristics make it a source of concern for individuals and families in rural communities.

The Sound of Silence

> 'It's not talked about at all, not at all...' (Male, 73, Interview 15).

Driven by the associated stigma, across the data study participants both inferred and spoke explicitly about a level of secrecy which applied to the discussion of depression, those experiencing it, and its possible treatment. Survey respondents were asked whether they personally and whether they perceived most others would be willing to tell people if they were experiencing depression. Almost one-third (30.5%) agreed to some extent that they would be personally reluctant to disclose such information. Further, and in a clear indication of the level of stigma and/or discrimination survey respondents felt to be likely in the community upon the disclosure of depression, three-quarters of respondents (74.7%) agreed to some extent that most people would refrain from discussing their experience of depression with others, with 30% of the sample providing a strong endorsement of this statement. Supporting these outcomes, at a broad level, interview participants outlined that the discussion of depression was frequently met with silence or, in many cases, discussion in this regard simply did not exist:

'Oh Jesus no! No! We wouldn't talk about that!... (we would) brush it under the carpet, yeah brush it under the carpet...' (Female, 43, Interview 5).

'If anything it wouldn't be (discussed), as I said, people would refer from talking about it. I know it's an awful word to say, but they would pity the family or the person that has it, but they wouldn't make it a topic of conversation, they would try and pass it off really...' (Female, 61, Interview 10).

'It would have the tradition of being a taboo subject hasn't it, you know kind of an underground illness... People don't like to say that their daughter or their partner or someone is suffering from depression, I'd say they would keep it as quiet enough as they could... I think people would still be quiet about it' (Female, 37, Interview 17)

Mirroring the importance of the meaning within silence in terms of the repression of sexuality as noted by Foucault (1980), this silence may be understood as exerting a considerable force upon the social discourse relating to depression as the emptiness it instils inhibits the establishment of any form of momentum required in order to change this scenario. Silence, when ingrained within and facilitated by the elements which contribute to a culture as is evident presently, is considerably difficult to break. The social environment in relation to depression was described by participants as such that the discussion of the condition was often not entertained. As a result, those who reported to have experienced the condition, or who were close to those who had, felt obliged to continue to maintain a degree of secrecy about their personal experiences:

'It (depression) was a very private thing for him (participants brother deceased by suicide) and he actually wouldn't have liked anyone to know. So here's a guy in his mid-40s and he still had that whole idea and thought around "Jesus, depression!" (spoken in an overwhelmed tone), as being something dreadful, as being something that you hide... it was awful for him, but it didn't mean that he was any less of a person you know, but he obviously felt that' (Female, 37, Interview 23).

'I have depression and I haven't really told anyone... If there was a conversation going on about it I don't think I would shy away from it or lie or anything, but at the same time I'm glad there hasn't been one eh, eh... I think most people would agree, I think most people would avoid a conversation about it' (Male, 25, Interview 2).

This apparent unwillingness to create space for the open discussion of depression across rural Irish society proved difficult for participants to understand with many, perhaps out of exasperation, referring to a reliable, and yet perhaps quite valid reasoning that this tendency towards secrecy in this regard has become interwoven into Irish culture:

> 'I don't think people will be open to admit that they had depression... because I think there is a taboo around it... and I don't know if it is that people don't want to talk about it, they don't want to bring it up in case they insult someone or something like that, but I don't know why it's not talked about, I guess it's just in our culture' (Female, 27, Interview 16).

> 'People just don't want to think that they can ever suffer from depression... there's a stigma yeah that's it, yeah definitely... I suppose people just think "I went through that for a while now I'm over it" and that all talk about it is very much a closed shop' (Female, 36, Interview 3).

In keeping with this suggestion towards the import of this learned culture, some participants mentioned the role of socialization in this regard, specifically their recollection of their childhood and formative years and the social protocols for the discussion of depression engrained within their memory from this period. In referring to such aspects, the considerable role played by the older generation in the transferral of their understandings of, and normal practices towards such social phenomenon (discussed in greater detail below) is suggested:

> 'When we were small we would have been thrown out of the house, they (parents) wouldn't want us to hear a thing about that (depression). If they were talking about something like that you wouldn't want to be there... things that are not out in the open, that's when the whisper comes in... the real old people, because it was okay years ago to call a person using a wheelchair a "cripple", that's what they grow with you know, that's part of the culture' (Male, 44, Interview 1).

Further to the suggested importance of one's formative years and sources of socialisation, a number of interview participants noted that the State was instrumental in the creation of this climate of concealment due to historical inadequacies in the area of mental health education. The absence of instruction in these matters, they felt, has meant the existence of a large swathe of the adult population with little literacy in relation to depression or broader mental health issues:

> 'It wouldn't have been educated in schools even, maybe today now it might be different, but when I was going to school there was never anything about depression or education about it and yet it was so common. So some education about it would have been great... I think people are very, very uneducated about it' (Female, 41, Interview 18).

> 'I don't think there was any education; I don't think there was any education on mental health!' (Female, 33, Interview 13).

> 'I think I an awful lot of it is just lack of, just lack of knowledge, lack of an awareness, and you know there is almost this thing of not wanting to engage with someone who is different I mean really' (Male, 61, Interview 9).

Gossip

> 'The truth is that gossip is as good as gospel in this town, you can save face but you can never save your soul, and that's a fact sir...' (Oberst 2002).

Without the precedence for, or the apparent current availability of an open and transparent forum, the general discussion of depression has become captured within the web of secrecy said to envelope culturally sensitive issues in rural Ireland. The data suggests that while secrecy is endemic, talk of depression remains highly prevalent but may be seen as forcefully degraded to a topic of local gossip.

> 'You would be amazed by what people know about people!' (Female, 36, Interview 3).

In discussion with interview participants on the many aspects which characterise rural community living, the existence of and participation in gossip were viewed as an integral part of social life in this setting as it appears understood that 'everybody knows everybody's business' (Male, 38, Interview 14). While seldom, if indeed ever an activity participants admitted to partake in personally, those questioned recognized the importance of gossip as a central method for the exchange of information within the community and also the apparent need or demand which exists for such detail by those who do participate:

> 'People do thrive on it, and it could be absolute rubbish and it just spreads like wildfire, people love it. I don't know why they love to talk

> about other people, maybe it distracts from their own issues... The sense that someone else has problems as well, but yeah definitely in rural communities (it's) important' (Female, 27, Interview 16).

Gossip is largely seen as an proactive activity involving engagement in rigorous investigations in order to ascertain often somewhat circumstantial detail then fed into a sophisticated, network structured conduit for further dissemination; 'the gossip mill' (Male, 40, Interview 22). This investigation is undertaken through the sometimes unashamed interrogation of neighbours and their behaviour with the aim being to decipher details of social or community significance. The criteria for this is determined by dominant rural philosophies which, as suggested and discussed in detail below, are perceived to crystallise around traditional conservative ideologies:

> 'They do pry a little... I mean we have neighbours now and they would press you for information you know, about random things, myself and my brother we have taken to just shocking them, just making stuff up like, just to take the piss out of them!' (Male, 25, Interview 2).

It is this perceived widespread, continual, and consistent individual contribution to a larger project of knowledge accumulation that gives gossip such power with participants extolling the efficiency with which information can be distributed across these network connections as they noted that frequently 'it only takes one person to know really and then it's off with the gossip' (Female, 35, Interview 20).

While a number of respondents were keen to stress that this propensity to involve one's self in, or witness the discussion of the affairs of others is not solely confined to rural areas as 'you have those gossipers everywhere!' (Female, 36, Interview 3), there was equal mention of the greater conduciveness of these same rural environments to this practice in comparison to more urban settlements:

> 'The gossip mill runs around rural Ireland a lot faster than urban Ireland because everybody knows each other, so if you have a problem in the community the next-door-neighbour probably knows before the doctor!' (Male, 40, Interview 22).

The seeming lack of selectivity in relation to what is discussed is supplemented by two other important rural-based factors; the relatively small size of the settlements and, as argued by a number of participants, what was described as a limited mindset among those

partaking in this activity. While the reasoning is seldom laid out explicitly, it seems almost taken for granted that the limited geographic area of rural villages and towns provides the ideal physical space for the transmission of messages via gossip among community members:

> 'I suppose because it's a small town as well, that if you tell one person then everybody knows. Small towns will be fairly good for gossip, as long as it's not about themselves! (Laughs)' (Female, 32, Interview 6).

> 'It would get out, I mean, yeah, I suppose because it's such a small place, yeah it doesn't take people long to find out' (Female, 35, Interview 20).

Described by some as 'busy bodies (who'd) be stuck in there no matter what you do' (Male, 44, Interview 1), those engaging in such activity were viewed most often with disdain by participants who cast aspersions as to the motivations behind their conduct which was frequently suggested to be due to the possession of a narrowed focus or small-mindedness, the product it is suggested, of an idle disposition:

> 'In rural areas people talk about people, maybe they're not busy enough or something (giggles), I wouldn't have time to being so busy at work... "Small minds talk about people, big minds talk about ideas"... There are certain people that you would know in the community that are like that, they are the talkers... they cling together you know, there is gossipers...' (Female, 36, Interview 3).

> 'There was a well-known local businessman hospitalised now since Christmas and word got about because of course it's a small town and people will be visiting friends in the acute unit and they will see who's in there... and it's amazing the amount of people that brought it up in conversation to my wife and I over that period, "did you hear that so-and-so was inside in the unit?"' (Male, 61, Interview 4).

Motives of Gossip

> 'I don't think people mean harm it's just that they are nosy, they might even wish the best for you...' (Male, 25, Interview 2).

Aside from the perception that gossip feeds the somewhat selfish whims of those involved in its proliferation, a small number of participants suggested that such exchanges also serve other, more noble purposes. Supporting the notion that gossip serves an

evolutionary utility (Barkow 1992, as cited by Foster 2004), among the most encouraging of such purposes mentioned relates to the role of gossip as the catalyst for the instigation of socially supportive actions among the community as information is disseminated which serves to alert those locally that a neighbour may be in need of some assistance. This information is said to be conveyed in a quiet and subtle manner in order to avoid causing insult or undue worry to the individual in question or their family:

> '...any bit of tittle-tattle and it's not to be malicious... it might be a way to pass on information about people, to keep an eye on them... out of concern; "have a look at that guy, he's not that well", that kind of thing... "such-and-such he's not been (well)..." And they would lower their voice and I suppose they are telling someone in confidence so they don't want everyone to hear it... it's gossiping but they don't see it as gossiping because it's not, it's telling somebody that someone "isn't well"' (Male, 44, Interview 1).

In this way, it is suggested, local neighbourly or community support may be mobilized and then applied to an individual who may be experiencing difficulties such as, and in the context of the interviews conducted, an experience of depression.

More often, however, respondents reverted to a more traditional perception of gossip which focused upon its power to scandalise. Reinforced by the weight of the social expectations discussed below, supporting the contention of Wilson *et al.* (2000), as cited by Baumeister *et al.* (2004), gossip was seen almost as a tool of social control used to chastise those who had breached strict guidelines for social behaviour as those who stepped outside of the bounds were seen to be made an example of. Participants outlined the tendency for such public rebukes to have malicious overtones, a fact which posed a significant threat to one's integrity and that of their family; aspects which, as outlined further below also, are of considerable importance in rural communities:

> 'They would probably interact all right and be all nice to your face but behind your back they are going (participant makes a contorted facial gesture)... I've been through it myself, people say "oh poor Josie she is divorced"... then they will say "well I hope she won't steal my husband!"... I think that's the way people are, they're probably nice to your face then behind your back they will say whatever, they gossip' (Female, 41, Interview 18).

Discussed further in the commentary on the use of euphemisms below, and also in line with the broader theme of secrecy, this scandalising faculty within gossip is said to be furthered by the covert manner within which gossip is actioned. For example, the emphasis upon the lowering of the tone of one's voice in order to impart the detail of the exchange seen as serving to denote a high level of scandal, i.e. that the utterance aloud of this information may in itself contravene social rules thus making the actual content itself appear more salacious:

> 'It would depend on how word came out even that you're depressed, I mean if one is going around speaking to people about it honestly then people might be more comfortable to engage with you and ask how you are, whereas if there is whispers going around about you people might engage differently with you' (Female, 37, Interview 25).

Depression as a Subject of Gossip

> 'It's the stigma again and again, especially in a rural area, everybody knows everyone and you know you just don't, you don't want anyone talking about you...' (Female, 33, Interview 13).

According to the survey data, the vast majority (70%) of respondents agreed that those with depression were likely to be the subject of gossip locally with 20% of the sample strongly affirming the sentiments of this statement. These findings support the interview data in which contributors lamented the persistence of such actions within the community and frequently questioned the motives of such behaviour:

> 'People definitely gossip... it has come back to me about my mother (experiencing depression)... They will be like "oh I know your mother had this and that or whatever" so people would definitely be gossiping... if they had something against the person or if they found out they were depressed they might, you know, be really happy about it' (Female, 32, Interview 6).

> 'Especially in small villages... you would get a lot of that there you know, "did you see him walking down the road there and he was chatting away to himself", you know. That would be kind of a polite way of putting everything you know, you would have that kind of stuff and it's not nice. And they try and pretend that it is out of concern where it's really just out of nosiness and trying to see "who else knows something that I don't know!"' (Female, 37, Interview 17)

Some even went so far as to imply a level of sadism is existent with greater interest and almost satisfaction seen to be forthcoming upon the deterioration of another's mental health through depression:

> 'It's the gossip machine working out the best you know, and then somebody who may be trying to commit suicide, that would be a really, really juicy bit of topic in an area for a while' (Male, 54, Interview 24).

This outcome is of significant interest given the suggested function of gossip as a source of social influence, as a vehicle for the promotion of social codes of conduct and dominant moral rules; cultural learning (Baumeister *et al.* 2004).

Use of Euphemisms

> 'People don't really understand depression properly so they will just say things like "oh her nerves are gone" or something like that you know, if people don't understand something they will just use the sort of one-liners' (Female, 35, Interview 20).

The manner in which the stigmatisation of depression is articulated through gossip and also within general talk is distinctive. In keeping with the notion of the culture of secrecy but also with the realisation that discussion is persisting in relation to socially salient issues such as depression in a covert manner, the *'Use of Euphemisms'* refers to the stated tendency for the use of seemingly ambiguous terms and phrases in order to avoid direct mention of depression; a practice described as widespread throughout the data. Further to the idea of stocks of knowledge which Habermas (1987) saw as key to providing a common background upon which actors may navigate social life, study participants noted the division and widespread dissemination of a subsection of vocabulary and phraseology utilized in order to circuitously discuss one's potential experience of, or treatment for depression. Mindful of the centrality of symbolic interactionism and of the language within that theory, the use and comprehension of the meaning behind this language is deemed crucial to contributing to and understanding the stigma towards depression in existence in this setting. The following extended batch of quotations are included in order to illustrate the breadth of vocabulary which exists in this regard:

> '"He suffers from his nerves"... "ah sure his brother died and it was an awful thing for the family" (whispered)' (Male 40, Interview 22).

'They'd say "he's just not well" or "he's not himself"...' (Male, 41, Interview 1).

'... "that one is half cracked" or "this one is half mad"' (Female, 59, Interview 12).

'"Oh that guy you know he's not the full shilling"' (Male, 38, Interview 14).

'"She's a bit touched and that", this kind of thing like, and so I understand she is on medication and stuff...' (Male, 25, Interview 2).

'"They are not in good form at the moment". That would be my understanding that they are depressed...' (Female, 55, Interview 21).

'"Oh he's taken to the bed that lad"... "God help him, sure he's not all there!"' (Female, 37, Interview 23).

Further to the qualitative data, the survey data also reveal the familiarity of the sample with the use of euphemisms in the discussion of depression. Eighty-five percent, 86.2%, and 40% of respondents who completed the question detailed that they had heard the terms 's/he is suffering with his/her nerves', 's/he is not well from time to time', and 's/he is a bit touched' used to describe a person experiencing depression in the previous twelve months, respectively.

Careful Whispers

'We'll talk low so the priest can't hear us (laughs)...' (Male, 25, Interview 2)

While the vocabulary employed in this process holds a certain degree of power within the interaction, according to interview participants, it is the manner in which such words are spoken that may ultimately determine the meaning behind their utterance with this too a product of cultural and traditional practices. As intimated and mentioned throughout the discussion thus far, participants noted that the almost covert discussion of depression based upon the utilization of phrases from this latent codebook of acceptable expressions was supplemented significantly by the application of a lowering of the tone of one's voice whilst discussing the subject:

> 'They would say you know, "I think he's downstairs in the hospital", that means he's in the area where people get treatment for mental problems you know, and that would be kind of whispered you know... (voice lowers to a whisper) "He's downstairs, it's not good you know", that's the attitude they would have.' (Female, 37, Interview 23).

The frequency with which participants mentioned this vocal adjustment, may lead one to believe that this practice has become a norm. The reasoning suggested for its application refers again to the sentiments of secrecy and discomfort in the discussion of depression discussed elsewhere. Further recounting Goffman's (1959) ideas in relation to face, participants suggested that this whisper-like conversation was conducted in order to convey confidentiality, as if engaging in a conversation with such content is in itself in breach of social rules, though whether this is achieved through its use is unclear:

> '"Such-and-such, he's not been (well)..." And they would lower their voice and I suppose they are telling someone in confidence so they don't want everyone to hear it... They think they are being a bit more confidential it's like, it's like "I'm trying to tell you a secret here now"... I think it's more that people do it subconsciously' (Male, 44, Interview 1).

So entrenched was this compulsion to lower the tone of one's voice around this subject matter that frequently throughout the course of interviews participants would, it seemed unconsciously, lower their voices to a whisper upon discussing some of the perhaps more sensitive points of the attitudes towards depression in their locality. While this was the case in instances both when other persons may have been in the vicinity of the conversation, i.e. when interviews took place in a public setting such as in a café, and while the interviews were conducted in more private settings, the author notes that it was more prevalent in public settings where others may have been within hearing distance of the conversation. This feature perhaps adds some further weight to references to the creation of an atmosphere of secrecy in relation to such matters suggested above.

Functions of Euphemisms

In combination with the above outlined feature, one may suggest that in line with politeness theory (Foley 1997), the prevailing inclination towards ambiguity may serve the purpose of cushioning interactants and others in their company from the severity of the subject matter. Within this view of euphemisms as a tool to ensure sensitivity, deference to this custom of circuitous, 'nudge-and-wink' form of conversation is described as

favourable to participation in an outspoken conversation applying terms which, though may be more accurate, are deemed to hold greater offensive power:

> 'Language is funny... Are they using it as a complete substitution for depression or are they using it in a way to say "I think there might be something up there but I'm not sure"?... "Touched", I mean "touched" could mean slightly handicapped, maybe a little simple you know in that regard, "away with the fairies" means borderline psychosis... That's just language you know, words just get appropriated...' (Male, 25, Interview 2)

Further to this idea of speaking sensitively, the utilization of euphemisms was also frequently viewed as due to a desire to excuse a person known to be experiencing depression from their behaviour or from full participation in daily activities. Frequently, in what may be viewed as a form of disempowerment, such euphemisms were interlinked with connotations of pity often in order to denote that the person in question is a victim to the situation or without power to change their circumstances. Many participants noted that the frequent use of such expressions served to infuse the sentiments they conveyed as defining features of the individual's identity in the eyes of others:

> 'I would have heard over the years my parents at home saying about "poor auntie Annie" (who experienced depression) and I would have grown up thinking about "poor auntie Annie". Now "poor auntie Annie" would have lived longer than all of them and would have had a better quality of life but, it took me years later to ask "why were they saying poor auntie Annie?"... I have had aunts who would have had heart attacks and it wasn't treated the same, and it wasn't with cancer either, it wasn't "poor auntie Mary" who had her womb removed, but it was "poor auntie Annie" and everything was excusable from her.' (Female, 60, Interview 11)

Other forms of euphemisms described by interview participants as serving as excuses for those with depression varied from those which appeared to suggest an anecdotal cause for such an experience, to those which appeared to favour an outright dismissal of the condition whose care or treatment was beyond the capabilities of most, perhaps with the exception of a deity (discussed in greater detail later), to address:

> '...people would say that "she is suffering from her nerves", the nerves that's what it is, "the nerves are at her now" (laughs).' (Female, 33, Interview 13)

> '... she would be walking away and they would be like "oh God love her", this kind of attitude, and you know "well God love her' (Female, 42, Interview 8)

Participants noted a tendency to verbally 'dance around' (Male, 44, Interview 1) the provision of an accurate description, erring towards providing expressions of complete ambiguity in their conversations in order to avoid either having to confirm or deny that depression was being experienced:

> '"They are a bit under the weather at the moment"... "oh well they haven't been well" you know kind of shrouded like that... "Oh sure there is no talking to him now at the moment", or "sure he has been locked up in the house now for a couple of days and he hasn't come outside"... that would be kind of a polite way of putting everything' (Female, 37, Interview 17)

> '"They are not in good form at the moment", that would be my understanding that they are depressed... It wouldn't be talked about as being depression, it would just be "not in good form"... you would hear it like; "their mother wasn't well" or "their father was in XXXX"... And when I say XXXX that would be a reference to the local mental institution. It would always be there, it is part of that known history' (Female, 55, Interview 21).

In line with the noted tendency to dismiss depression and those experiencing it, participants also noted that frequently euphemisms were used in order to discredit, insult and/or undermine the person experiencing depression. This was achieved via the depiction of such individuals as 'half-mad' (Female, 59, Interview 12) or 'not well in the head at all' (Female, 37, Interview 17) among other insulting identifications with such language and phraseology employed in order to excuse, dismiss and/or discredit both the condition and the experiences of the person with the condition. Frequent reversion to attempts to attach causation to individual or familial character flaws is also noted. Mindful of the above mentioned tendency towards creating an air of secrecy through the lowering of the tone of one's voice during this discussion, such language was viewed by some respondents as a form of indirect undermining whereby the suggestion of infirmity or inability is planted into the conversation. This is done again in an ambiguous fashion such that uncertainty in relation to the individual under discussion and their experience of depression is the understood outcome:

> 'You were presumed you were mad... You were "a lunatic" or "he's not right in the head" that kind of thing, you know what I mean? "You've to be careful with him" (nervous laugh)' (Female, 37, Interview 19).

> 'It would be "he can snap out of it", "he's just not feeling well", definitely... "oh he's only looking for attention now", yeah you would hear that definitely' (Female, 33, Interview 13).

Other such comments focused upon undermining the credibility of both the individual and the condition with suggestions that a person reporting to be experiencing depression was doing so to garner some attention or benefits of some description, a suggestion which implicitly devalues depression as a condition meriting care:

> 'There would be comments like "she is off her head", or "she is mad", "she is going down there now are getting a free lunch" you know with the mental health services. "Sure there is nothing wrong with that one, she's just playing it all up"' (Female, 42, Interview 8).

> '"They are only being stupid" or "being silly" or "cop themselves on and get on with life"... You do hear that!... "Sure what's wrong with her or him? They have everything going for them! Look at me, I have no money or this or that and I'm getting on with life"' (Female, 59, Interview 12).

Interview participants noted that as well as the indirect, passive mentions, other more explicit and potentially damaging euphemisms were also in use with, yet again, these hard-hitting statements placing the emphasis upon the depiction of unpredictability and instability:

> 'You have the derogatory statements like "you're mental", and nobody wants that' (Male, 38, Interview 14).

> '"She's a nutter!", "She's as mad as a hatter", "say nothing to nobody"' (Female, 43, Interview 5).

> '... and sometimes conversations would happen with children against her children you know, "go away sure your mother is a head-case" this kind of stuff' (Female, 42, Interview 8).

'Biographical Others'

> 'Especially in rural areas where we are very prone to our gossip and to labelling families anyway, calling people nicknames and stuff like that, if you have one or more members that are prone to something, be it great workers or great drinkers, you know people can get names for it... You encounter that more rurally than you would in an urban setting, people are more into genealogy and traits and families and stuff like that' (Female, 37, Interview 25).

In considering the gossip said to persist in relation to depression in rural Irish communities, we are provided with a key example of what Goffman termed the 'biographical others' at work within this setting. Noting that 'people would tend to know families and family histories and things like that' (Female, 61, Interview 10) within rural communities, this aspect also provides evidence of the tendency of those involved in such biographical efforts to include historical references in their efforts to 'place' an individual. This is achieved via the creation of personal and familial narratives, in each instance, in a sense, imposing a courtesy stigma from previous generations upon descendent individuals presently (Goffman 1963). While it is not suggested to be a solely rural phenomenon, this conferral of ancestral attributes is certainly viewed as a more common and established practice in comparison to urban settings owing to typically small populations facilitating easier identification of individuals and families, thus making 'your standing in the community, your family's standing in the community... more visible and more obvious' (Female, 61, Interview 9). Such actions may be seen to produce powerful symbolic and tangible implications pertaining to the possible denigration or elevation of one's family name, and/or the identity of a related individual:

> 'It would be the character or whether it's in the family or look at what her mother did and her father... Especially in rural areas because people love just talking about other people and it's probably that everybody knows everybody... and (it) can be quite hurtful' (Female, 33, Interview 13).

> '"Oh sure they're the same as their grandmother", they would be associated with somebody else in the family whether it was a parent or grandparent or great grandparent or granduncle or whatever but sometimes you hear people say "sure they are the same as such-and-such belonging to them"... "sure God love them, what other way would they be, sure wasn't Paddy the same as that"' (Female, 37, Interview 17).

> '"Sure they are all mad"... "The mad blue eyes in that family", you know people just tend to generalise... That's pretty much rural Ireland though, you know if one person in the family back (years ago acted) slightly irrationally for whatever reason, you would look for traits, the older generation more so than us... "Their aunt was this, and sure their father was a well-known..."' (Female, 37, Interview 25).

Throughout the discussion participants expressed a personal and familial desire to remain outside the remit of consideration of those who partake in local gossip. With the expressed understanding of the likelihood that one's depression may form the basis for investigation within this process of biographical data collection, and mindful of the potential for the imposition of a courtesy stigma upon a family and their potential discreditation, significant concern was expressed together with acknowledgment of the need for a strong response in order to avoid this outcome. This response centered upon the maintenance of the utmost secrecy:

> 'I would have had concerns about my ex-husband (experiencing depression)... I went and spoke to his sister about it and she said "oh don't be ridiculous! No, no he is not like that at all!"... a lot of times family members don't even want to see it in case it is real and then you have to deal with it. It's like "we are fine!"... So I think that could be a culture, a family culture thing... and it will definitely come from as well, you know, the perception of "what will other people think of me? What will other people think of my brother or my sister, mother or..."' (Female, 37, Interview 17).

> '"Do you think he might be depressed? Well he might be down in the dumps but sure he's grand"... if you're talking about husbands or sons, it's always, there is never actually a full commitment to say "yeah my husband is depressed or my son might be depressed"... Because then everybody will be talking about him, "oh he has a problem, he has a problem"' (Female, 33, Interview 13).

Summary of 'Culture of Secrecy'

The consistent stigmatisation of depression has led to, and may also be seen as sustained by, a culture of secrecy. Study participants noted their perception that the suggestion of the open discussion of depression in their community would be met with silence owing to a palpable sense of reluctance to converse candidly about such issues. While this silence persisted, study participants did, however, note that covert discussion of the topic persists; relegated to the subject of gossip locally. Being discussed under a cloud of suspicion and

trepidation, participants provided details of the existence of a distinct set of communicative tools used in this instance that centre upon an appropriated elaborate and circuitous vocabulary which most often worked in unison with the adoption of a tone of voice; symbols designed to convey secrecy, the sense of confidentiality, and deviance. It is through this communicative arrangement that information is perceived to be circulated around the community thus facilitating the compilation of personal and familial biographies with the presence of depression an attribute meriting inclusion.

Summary and Conclusion

This chapter presented detail of how those who took part in this research viewed depression to be stigmatized in rural Irish communities. Supporting Thornicroft's (2006) tri-partite approach to stigma, participants perceived a level of ignorance across rural society in relation to depression as evidenced by a noted propensity among many to dismiss the condition as outside of the realm of illness, stereotype those labeled as experiencing the condition often as nothing more than holders of a personal weakness or failing, followed by moves to discriminate against this cohort. This discrimination is said to predominantly manifest in the form of social distancing from, and avoidance of the affected individual or cohort together with efforts towards the provision of legitimization for such actions. Upon further exploration, it emerged that such activities were perceived as motivated by fear in relation to one's physical and emotional wellbeing, the wellbeing of one's children and family, and in some cases fear for negatively impacting upon the wellbeing of the person experiencing depression.

A culture of secrecy is said to persist in relation to depression in rural Ireland. This cultural trait and the factors of stigmatization can be seen to work in unison with each serving to further the impact of the other. This supposed secrecy which is said to envelope depression resembles an open secret, with the discussion of depression continuing, however, without the level of openness, transparency and ease which accompany other conditions of ill health or social concern. As a result, the discussion of depression has been consigned to feature within the circles of local gossip which have developed and maintained a specific language and method of communication in this regard. The very placement of this discourse within this arena of discussion may be seen, due to its

potentially scandalising impacts upon family reputation among other factors, to have driven the subject deeper within the realm of social untouchability and deviance.

One may conclude that the evidence presented supports the suggestion that depression is understood to be in receipt of significant stigma in rural Ireland.

Chapter Six - Drivers of Stigmatisation

Introduction

The previous chapter discussed the stigmatisation of depression as viewed by the present sample of residents of rural Ireland, and presented their views as to the cultural aspects which are both the product of this stigma and the facilitators of its proliferation. This chapter will explore the underlying social and cultural factors driving this stigmatisation in order to provide a comprehensive understanding of the key factors which have enabled the perceived present discrimination.

In order to achieve this end, what follows is a discussion of the drivers of this stigmatisation presented under the following themes; *'Social Norms, Values and Expectations'*, *'Suicide'*, *'Role of Mental Institutions'*, *'Role of the Catholic Church'*, *'Role of the Media'*, and *'Generational Differences'*.

Social Norms, Values and Expectations

According to interview participants, the populace of rural Ireland is bound by a set of norms and values which act to shape behaviour, together with an expectation that these norms and values are adhered to. While some argued that rural 'society has changed immensely' (Male, 40, Interview 22) in recent years, one may contend that a number of core aspects traditionally associated with rural existence remain intact and exert considerable influence upon the manner in which life is lived within such settings and, crucially, the stigmatisation of depression there.

'Social Norms, Values and Expectations' refers to the social conventions of rural society suggested by study participants as being central to the endurance of the stigmatisation of depression as a feature within rural culture. This aspect is discussed within the following sections; *'Lack of Anonymity'*, *'The Importance of Family'*, *'"Keeping the Good Side Out"'*, *'Reservation and Conservatism'*, *'Bog Warrior'*, *'Sexuality'*, and *'Maintenance of Tradition/Regeneration of Norms'*.

Lack of Anonymity

Discussion of factors influencing such stigmatisation must be framed within an understanding of the intense social relations which study participants suggested are typical within rural environments. As mentioned within the above commentary in relation to *'Gossip'* and *'Biographical Others'*, rural living is deemed to be characterised by a lack of anonymity with life in such communities described by participants as defined by one's participation, whether desired or otherwise, within an intense network of social interaction. Often by virtue of its geographical configuration and frequently low population, participants understood that rural communities were somewhat unique in the high level of interaction members may have:

> 'In rural communities you are interacting with the same people in many different roles... so that you have this more intense relationship web, it's a smaller number of participants but thereby more intense... you almost can't hide, there is nowhere to hide...' (Male, 61, Interview 9).

> '(It's) a rural thing more-so as well, I suppose in cities and towns you don't know because people don't really know their neighbours, whereas in the more country areas everyone knows (everyone)...' (Female, 35, Interview 20).

The recurrent explicit mention of acknowledgement of the apparent hyper interconnectivity of those in rural communities, aptly articulated in the "everybody knows everybody" maxim and variants thereof, is also noticeable with the implication that the anonymity one may expect or desire in the conducting of their affairs in this setting is limited:

> 'If I had been living in (name of village) when I had got sick first (with depression) I don't know how easy it would have been to go down to the local pub for a drink... I would have felt a consciousness... if you go into a smaller pub in (name of village), probably people would have known and would I suppose be asking, I don't know if prying would be a better word but, you know, 'twasnt as easy getting away from it you know because (name of village) was very rural' (Male, 61, Interview 4).

> 'They won't access it (counselling service) in (name of village)... but they will come to (name of nearest town) where the counsellor has a facility that he uses... so that nobody finds out that "Johnny" or "Mary" are gone for counselling' (Male, 38, Interview 14).

Acknowledgement of this perceived lack of anonymity, extending almost into an incursion upon one's privacy, and the influence this is said to have upon behaviours and activities, is of crucial importance to understanding stigma in rural Ireland.

The Importance of Family

Further to the discussion of *'Biographical Others'* above, the outlined lack of anonymity may be seen to be facilitated by the presence of, in some instances, vast familial networks in rural communities. Such communities were seen as extremely family oriented environments with a tradition of limited individual or familial mobility meaning that often interview participants expressed witnessing, or being part of themselves, communities in which a significant proportion of the limited population were related to some degree:

> '(In) the village, let's say if you asked them all to hop up if we were related, everyone would jump up because the whole village and surrounding areas would be related' (Female, 59, Interview 12).

> 'Things remain hidden because of the likelihood that the person one is discussing may be related to the other participant in the conversation... there is a lot of hidden things within rural communities, that there is not maybe an openness to discussing things or people admitting things or having someone to talk to because invariably... somebody is related to somebody's third cousin' (Female, 43, Interview 7).

Family was detailed by participants as playing a crucial role in rural life representing an instant social network from which it was viewed that support can be sought and received. This intricate web of relations may be seen to provide an established framework in which one, depending upon the position of their own family within same, may base themselves. It is at once a form of identity and a vehicle for inclusion (or exclusion) within a social environment as, noting the propensity to recount family histories, one's family connections offers others the ability to 'place' an individual. A process and phrase, both noted by Goffman (1963) but also featuring within common parlance in rural communities, 'placing' refers to establishing the likely personal qualities of an individual based upon an understanding of the known traits of their ancestors. While this offers in the least the opportunity for inclusion within a social network, it was also noted that the presence of this network bound as it is by familial ties, may prove a difficult and time consuming structure to penetrate to those without such kindred affiliations:

> 'I have an uncle up the road who I would be rarely in contact with, but the minute that they (neighbours) found out that it was my uncle then the door kind of opened slightly; "you're related to a (name of village) person?!"... in a lot of the rural areas you are either a cousin or cousin's cousin and all that sort of thing whereas if you're moving in from outside its very, very difficult' (Male, 38, Interview 14).

Mindful of the frequent presence of complex family networks within rural communities and of the weight of numbers within this network, significant emphasis was viewed by study participants to be placed upon the upholding of the high stature or "good name" of one's family. This is a task fraught with difficulty owing to an apparent environment conducive to the imposition of attributes upon a cohort of related individuals based essentially upon any foray into behaviour outside of a predetermined normality by a member or members of this group:

> 'Definitely a cultural thing you know... you never wanted anybody in the family who was different and if there was something wrong with someone you didn't talk about it' (Female, 37, Interview 23).

As discussed in the commentary on *'Biographical Others'* above, while not suggested to be a solely rural phenomenon, this conferral of ancestral attributes is certainly viewed as a more common practice and a more established method of "placing" an individual in comparison to urban settings as 'your standing in the community, your family's standing in the community... (is) more visible and more obvious' (Female, 61, Interview 9):

> 'If one member of the family is suffering like this (with depression) it sort of brands the whole family... "well sure there was his uncle now back 50 years ago he wasn't much better" - that type of conversation will be heard in rural areas' (Male, 54, Interview 24).

Acknowledging this tendency among locals, participants outlined a level of pressure upon each family member which results from this social identification mechanism, discussed with specific reference to the experience of depression, to project a certain level of normality in order to avoid being drawn into this attribution process. This pressure to conform is sustained due to a desire not 'to let the family down or be seen to be letting the family down' (Female, 27, Interview 16), or, indeed, by a wish to relieve oneself of an inherited classification:

> 'They keep the facade up more than people might do in other settings because, you know, it's the name, or the family, or the risk of some way being embarrassed by this revelation. So there is a strong tendency to hide this (depression)' (Female, 60, Interview 11).

As this quote suggests, throughout the data it was detailed that there exists a considerable 'fear of shaming the family' (Female, 35, Interview 20) with the experiencing of depression deemed as among a list of circumstances liable to make this fear a reality. Study participants noted measures taken to avoid the potential encroachment of a shadow upon a family name which ranged from the covert dealing of the case as described above, to a wilful ignoring of the situation in its entirety in the hope of its disappearance, to, at the extreme end, the stern intervention of senior family members in concerning scenarios in order to protect against a perceived threat to family honour.

'Keeping the Good Side Out'

Itself a common saying which may be argued to offer an insight into social priorities, '*Keeping the Good Side Out'* refers to the desire to project positivity and exuberance in social interaction. Complimenting Lim and Waite Bowers' notion of 'competence face' (1991, as cited by Miller 2005), an extension of Goffman's (1959) original work in this vein, mindful of the abovementioned factors, throughout the data study participants suggested that in modern rural society a high value was attached to achievement or indeed the perception that one has achieved a high standard of living within the framework of understood social norms and values. It became apparent that participants envisaged aspects of modern rural social life as akin to an almost mandatory form of competition with the competitor's desire being to establish themselves among the elite or, in the least, amongst the dominant cohort:

> 'There is a huge emphasis on being the perfect figure, the perfect appearance, the perfect farm, the perfect wife, the perfect hair, perfection is what we value hugely in society... nobody wants to have any involvement with anybody less than perfect because it's kind of bringing them down... we have moved away from helping the weak people... It is absolutely elitist' (Female, 60, Interview 11).

As intimated, interview participants lamented this penchant for the achievement of a form of perfection as undesirable as it was often based upon the attainment of unrealistic goals. Further, and aside from this issue, this proclivity to attainment created a skewed sense of

reality as it was felt that outside of the limited cohort who may achieve, or at least give the impression of achievement, what remained was a large section of society made to experience a sense of failure due to their supposed lower standing:

> '"Keeping up with the Joneses" is a big thing as well, that leads people to feeling inadequate. Aspiring to get to maybe where the neighbour is. And then they (those experiencing depression) would imagine that it has gone totally the wrong way for them and they hang on to the hope of keeping on the path towards this "great life" which I suppose is not as great as people imagine' (Male, 54, Interview 24).

To counter this perhaps, participants noted a significant tendency towards the presentation of an elaborate front of success in order to disguise the relative "imperfections" of a person's situation towards the preservation of a desired image:

> 'We live in a society where the strongest survive I think and people are striving to have the best of things, striving to have their cars and houses, and any sort of weakness you know if it is visible, they won't be happy with. So they try and fake a smile if you like, or try and fake that there is nothing going on' (Female, 37, Interview 26).

> 'Everyone just wants to be happy all the time... they just don't want to, you know, admit that they might be feeling down or whatever... no one wants to talk about anything depressing I suppose, no one wants (anyone) to think they can't cope with something... You look better in society if you can cope better with everything and you seem like everything is going, you know, hunky-dory and I suppose that's not the reality' (Female, 36, Interview 3)

The drive towards achievement and the presentation of same is inferred to be structural in nature with significant reference to, as an example, an education system biased in the favour of supporting those with stronger academic capabilities and perceived to be predicated upon an almost exclusive zeal towards the attainment of high exam results above notions of personal development through learning. With acceptance to third level education based upon the accumulation of points yielded from a series of examinations at the end of secondary education, "the points race" was mentioned frequently in discussion of this competitive society and serves as an example of the structurally ingrained pressure to achieve encountered by children within the State from early adolescence:

> 'There is also a lot of pressure now particularly around exam times. I know that there would be a number of suicides in (name of village) because too much pressure was put on students... there is too much of a focus on the points race' (Male, 40, Interview 22).

The educational attainment of the broader survey sample from which the majority of interview participants are drawn may be viewed as indicative as to the content of the commentary on educational achievement however, as the broad sample is well educated with 62.1% attaining at least an 'Honours Bachelor Degree or Professional Qualification' while the highest represented cohort are those who have attained a 'Postgraduate Diploma or Degree' (31.6%).

Further to education, referencing functionalist sentiments, the importance of those in rural areas holding the ability to, and being seen to be productive in economic activity gains considerable mention. Acknowledging the growing movement in Irish society towards 'becoming more and more Americanised where you must be working five if not six days a week' (Female, 37, Interview 25), repercussions based upon the conventions of past attitudes were seen to be expected if one falls short of this standard:

> 'Children were there to be productive and if someone couldn't engage for whatever reason they were seen as lesser in some way, with some handicap or other. So if you had somebody every year... who would have to be taken away or who wasn't able to engage with active life when they were needed on a farm... there was maybe a bit of an annoyance to them or stigma towards them' (Female, 37, Interview 25).

> 'People always had to work and there was always children to be minded and there was always bread to be put on the table so you had to go out and work. You couldn't sit at home and feel sorry for yourself... Or you're just being lazy you know, and I think that's where it's (depression stigma) coming from' (Female, 33, Interview 13).

This focus upon the economic productivity of the individual is supplemented further by notions of pride discussed elsewhere which also point to the tendency to measure aspects of a person's worth via an appreciation of one's ability to provide both for themselves and others. Interview participants noted that penetrating the meanings and symbolic significance behind this strong work ethic and the centrality of the ability to provide was of importance to understand rural society and may indeed provide an angle should one wish to comprehend the seemingly greater reluctance to admit weakness in such communities.

Referring to the outlined need for perfection, particularly among males, being dependent upon others for one's survival in any sense was deemed inadequate and unlikely to be tolerated:

> 'Rural communities, particularly farming communities, they are more self-sufficient, they expect themselves to do more things for themselves so that then any kind of failures are more... obvious because they are set in the context of expecting to handle everything... we mind ourselves and look after ourselves... And so failing to do so is then a bigger failure' (Male, 61, Interview 9).

Reservation & Conservatism

Perhaps linked to the desire to avoid discussion within local gossip discussed above, central to what is deemed appropriate and desirable by participants in rural Ireland corresponds to an overall sense of reservation. This is a quality which may be viewed as intimately linked with the emphasis placed upon Catholicism and the conservative values espoused therein, both mentioned above and discussed in further detail below:

> 'I mentioned the Church because of the culture in the country you know, that everybody had to do "the right thing" and everybody had to be seen to be doing "the right thing" and so if you weren't, well then, it wasn't acceptable really' (Female, 37, Interview 23).

While their urban, 'townie' counterparts are viewed as more likely to openly air their feelings and emotions and conduct themselves in a more carefree manner, stoicism was viewed as a desirable quality in rural settings. Participants outlined that one is encouraged to adopt a more guarded stance and in doing so yield little indication to others which may suggest the experience of anything other than the socially desirable lifestyle:

> 'We have people who volunteer on a Friday... this lady had too much to drink one night and she is a single mother and young and got up on a table... they were dancing around kicking a few glasses off the table and the following day then (a parent) comes rushing in and says; "oh we can't allow that one as a volunteer anymore!" It had gotten around and had come back and the response was that "oh we can't have the likes of her now"' (Male, 38, Interview 14)

Some participants aligned this reservation with a strong desire for privacy; an unwillingness to open one's life, and potentially with that the lives of one's families, to the

view and scrutiny of others. Participants remarked that maintaining such privacy while passing oneself socially is achieved through participation in cyclical and generalised conversation thus avoiding meaningful conversation in which personal aspects may be disclosed:

> 'Everyone is very private but very social... it's the one thing about home that gets on my nerves after a while, constantly talking about nothing! It's this kind of loop of "you know this guy built a wall" or "isn't he a first cousin of this person" "and their related to them over there", you get into this infinite loop... It's an awful lot of talking, but the personal things they're left out' (Male, 25, Interview 2).

Further to this, participants also outlined a linkage between reservation, privacy, and strongly held notions of pride among those in rural communities. Heightened by an awareness of the lack of anonymity and the importance of family reputation outlined above, participants noted the necessity to remain stoic in order to avoid the steady dripping of sensitive personal information, or to avoid becoming the target of extraordinary local attention within the community:

> 'Pride is a big thing... because farmers, or even people living in rural Ireland, they tend to keep things to themselves... So there is a pride element in keeping things in...' (Male, 40, Interview 22).

This aspect is discussed in greater detail in the commentaries on gender and family below.

'Bog Warrior'

> 'It comes back to our culture, and you see American men hugging each other and you know it's really like "how are you?!" and this kind of thing. But the boys here and the men here don't seem to do that...' (Female, 27, Interview 16).

Feeding into the finding that depression is viewed as a form weakness in rural society, the implications of gender roles are seen by study participants as crucial factors in the proliferation of the stigma towards depression. Most notable throughout the data is that discussion of the broad concept of gender, when intimated alongside the issue of depression and stigma, very frequently reverted to the exclusive discussion of rural masculinities.

> 'The high suicide rate is something that I can't seem to get my head around... the majority of the people that are in the demographic are young men, would that be depression? Is it just all over depression or that they have depression? Or would trying to change people's attitudes with that lower the suicide rates?... It's just something that we can't seem to figure out, is it just that young men, or men, are just not taught to talk from a young age and is that where that stems from?' (Female, 27, Interview 16).

'Bog Warrior' refers to the consistent reference made throughout the data to the expectation for men in rural Ireland to maintain what is viewed as a traditionally manly persona, a persona which, due to it being perceived as a source of weakness, does not include an acknowledgement or discussion of depression or aspects relating to ones' emotional wellbeing:

> 'It's "I'm a man!" (said gruffly), it's macho... men probably don't want to say things because they don't want people thinking they are less of a man' (Male, 44, Interview 1).

> 'You kind of associate it (depression) with a fragility, especially for young men like I think that's very hard... like my brother (deceased by suicide) was "a man's man", into hurling, shooting and football and was an intelligent man, but he did not want to be seen to be letting the side down' (Female, 37, Interview 23).

The expected behaviour for men appears at once loosely defined, but yet also possessing a degree of clarity as the role of socialisation in this regard and the learned traits it imparts may be seen to be formative in creating an understanding of acceptable conduct. Such an expectation of gender-specific behaviour appears to be rooted within culture due to the historically defined roles afforded to men and women in which strength, and/or the perception of, remains intrinsic to the male identity:

> 'I wouldn't be very comfortable if a man started crying... I don't know if it is because my father would have been a very supportive man figure, I would have never have seen him cry... I just wouldn't feel very comfortable seeing any other man do it... I still wouldn't like to see him (husband) crying because it would make me feel that he wouldn't be able to protect me... maybe there is that gender thing there that women can bitch and moan and men can't' (Female, 30, Interview 26).

The data suggests that deviation from this particular gender role is viewed as unacceptable and likely to impact upon one's social progression in rural society:

> 'Younger farmers I think, it would be very difficult to pin them down, they are less (open)... Because they have too much at risk to start accepting that they may have some areas they need help with' (Female, 60, Interview 11).

Further, such divergence from the accepted and understood norms, particularly when linked with an expression of viewed weakness, is also seen as likely to cast aspersions as to the identity development of the individual and likely to be seen as a failure to fulfil the gender role sufficiently:

> 'I have a 20 year old son and I had noticed that he had not been himself lately... it turned out he was being bullied at work. I said it to my husband... even he said "he didn't go crying to his mammy about it did he?!" I said it to him the next day and he said he had thought about it overnight and regretted it... but it was something that just came out... I was so angry, and he is an intelligent man but it's what he just said – total bog warrior stuff!' (Female, 37, Interview 23).

The frequently stated outcome of the pervasiveness of this cultural trait relating to a male gender role steeped in an expectation of machismo and characterised by an near introverted sense of resilience, is that most participants felt that males held a fear of discussing their feelings or of talking openly, even among peers, in anticipation that they may then fall outside of social expectations:

> 'I know that they (male friends) wouldn't discuss depression amongst themselves... it may be a macho thing, maybe they possibly might discuss it with their partners or girlfriends but I know that they wouldn't talk about it amongst themselves... And that's probably a macho thing because, eh, it might be a sign of weakness' (Female, 27, Interview 16).

> 'They (men) tend to go to the doctor less, so when you go to the doctor you tend to divulge... The whole thing is they want to be strong and they don't want to say there is anything wrong, it's the whole "man thing"' (Female, 36, Interview 3).

As mentioned above, a further suggestion offered by participants held that the very intimation behind removing a guarded stance to the discussion of personal emotions posed a potential threat to male pride; a notion itself immersed within this apparent macho culture which holds self-sufficiency, forthrightness, and resilience to the fore. As well as personal feelings of self-worth harboured by such pride, study participants noted it is

directly connected with a consistent theme throughout the data relating to the understood preoccupation with how one is viewed by the wider community:

> 'I fear for men it's just, they might have more pride that they wouldn't talk about things like that... I live in a very rural area, I also would work in the local pub which would be frequented by mainly bachelor men... and I don't know if it is pride or secretiveness or what it is, but if you ask "how are you doing?", you will get "grand". Even if you know that their mortgage has been taken off them or they have attempted suicide or something like that, and in a small village you hear these things, they still answer "fine"... For men, its seen as being weak to suffer from depression so that way they won't talk about it' (Female, 30, Interview 26).

Perhaps as a result of this ingrained propensity towards the inversion of emotions, and suggesting the cyclical nature of this situation, participants, both male and female, note that males are perceived as invariably emotionally stunted, unable to provide empathy in situations pertaining to depression or other issues of an emotionally sensitive nature:

> 'To talk about the softer issues, the touchy-feely stuff, men wouldn't really want to know about that at all, they would run away! It wouldn't be a macho thing at all especially for middle-aged rural men in Ireland' (Male, 54, Interview 24).

> 'Is it just that young men, or men, are just not taught to talk from a young age?... When I'm with my girlfriends we just talk the hind legs off a donkey, and we talk about anything, but I know that the boys just don't... there could be work done by teaching young boys from a young age that it's okay to talk' (Female, 27, Interview 16).

One may suggest that the sentiments outlined above in relation to a perceived aversion among males towards a progressive understanding of depression are supported to some extent within the survey data. Considering the personal stigma scale and perceived social distance scale data, proportionately more male respondents report views which display personally held stigmatising views and a perception that others desire greater social distance in relation to depression than female respondents within the sample. Chi square tests were carried out to test the null hypotheses that there is no association between gender and total personal stigma scale ($X^2 = 7.381$; df = 2; p = .025), and between gender and the perceived social distance scale ($X^2 = 7.011$; df = 2; p = .030). Evidence was found to reject these null hypotheses and the strength of these associations indicated some

support for these relationships within the target population. Further, when controlling for age, the responses of those males aged forty years or younger to both of these scales is noted as more prejudiced than those offered by females within this age cohort, and both males and females within the forty-one years and over cohort. Statistically significant association between gender and total personal stigma scores was present only in this ≤ 40 cohort (X^2 = 7.196; df = 2; p = .027) (see Figure 3), while within the perceived social distance scale the statistical significance of this outcome within the ≤ 40 cohort (X^2 = 6.164; df = 2; p = .046) is also evident (see Figure 4).

Figure 3: Sum of Personal Stigma

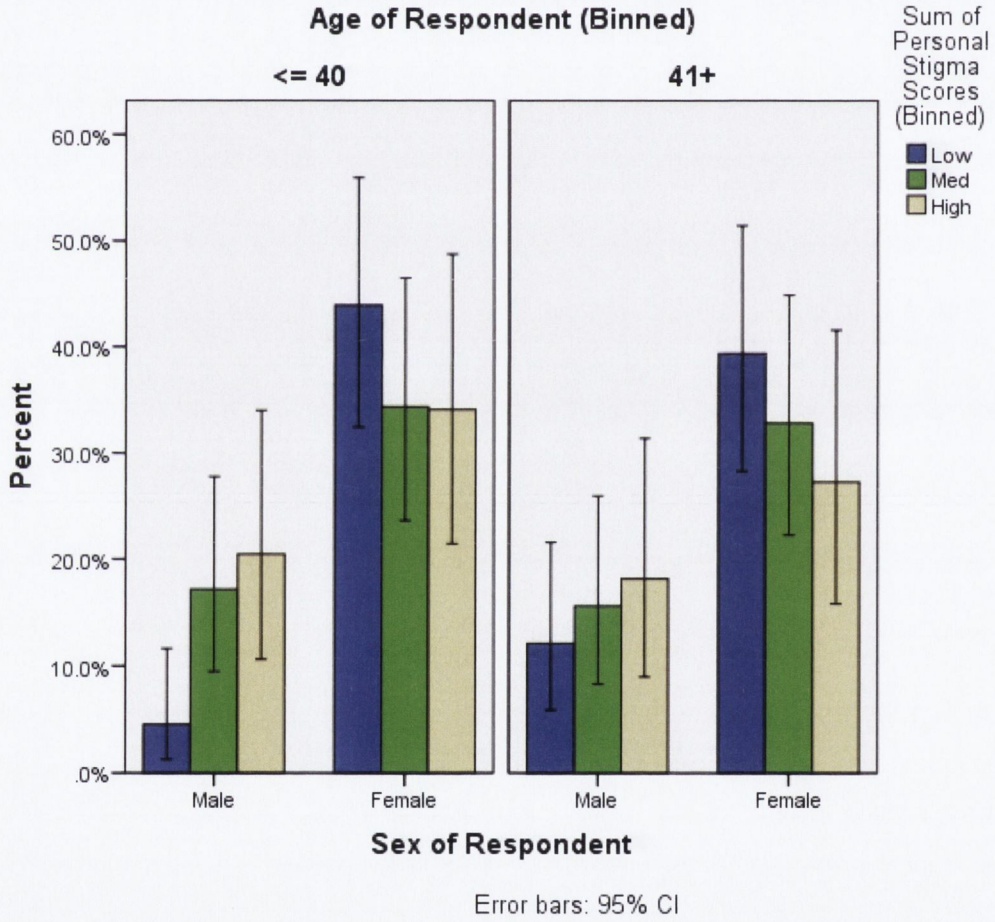


Figure 4: Perceived Social Distance



The charts above outline visually the chi square tests of association. The whisker at the top of each bar indicate the 95% confidence interval of the proportion in the population.

Within the perceived stigma scale, though no statistical significance is noted, younger male respondents present a higher propensity to perceive that others in the community hold stigmatising views than older males, and both younger and older females.

While the overall trend of the sample was largely towards low personal stigma, the high proportions of males, and indeed that key demographic of young males, with higher personal stigmatising views may be suggestive of a somewhat greater sense of apathy or lower understanding of the condition among this cohort. Further, considering males hold higher perceptions of both stigmatising attitudes among others, and of others want for greater social distance, when taken in combination with the aforementioned outcome, one

may suggest that males in particular are acutely aware of, or indeed themselves perceive, a tide of negative attitudes existent across rural society in relation to depression.

Adding to the concern expressed in relation to males in rural Ireland, a number of participants sought to highlight the changing gender dynamics within this setting. Whereas traditionally the male role is seen to have centred upon their primary position as the breadwinner afforded by their dominance in the economic and occupational realms, recent economic developments in Ireland overall, but suggested by participants to be magnified in rural communities, have led to a substantial change in this established order. The role of the male is seen as being undermined on a continual basis leading to fears for the impact of such erosion upon rural male identity:

> 'I don't think they (men) know what their purpose in life is... their roles aren't as clear as ours were you know, and I think on farms it's the same. Well like, what is their role? Is it to be the father? To provide the income? To parent the kids? That's all gone from them because they have a wife who is earning more, so it's not the economic role, they are not the income earner which gave them status and power and made them feel good about themselves' (Female, 60, Interview 11).

Sexuality

> 'You see in the news now things about gay marriages and civil partnerships and things like that, so that's okay now whereas that's another thing which was probably very much wound up in the depression thing where people just felt that they were totally misunderstood' (Female, 37, Interview 23).

Throughout the data, constant comparisons between the statuses of depression and homosexuality in rural Ireland are notable with the inference that the two issues hold significant similarities in terms of how they are perceived to be viewed by the rural population in the main. It appears that 'depression and being gay... are two things which are kind of swept under the rug' (Female, 27, Interview 16) in rural settings owing, it is suggested, to the understanding of the presence of intolerance towards both in that social environment:

> 'It (the stigma of depression) is like years ago... it was a criminal act to be lesbian or gay... There was a lot of this old crap going on, and the

> more you talk about these things the more it becomes acceptable...' (Female, 42, Interview 8).

Participants outlined the existence of 'the smirk and elbow' (Male, 38, Interview 14) culture in this regard with a sentiment expressed that homosexuality held a position as a target for hostility. Some participants detailed both the expectancy and experience of witnessing a lack of acceptance of homosexuality among those in their communities with opponents described as comfortable in their ability to be socially outspoken on the issue:

> 'We had a guy down (in work) talking about gay awareness and all that. Now this fella was very camp, a lovely fella, but one of the guys he could have went out through the back wall!... Myself and my wife were down at a friend of ours and he's gay and he got married to his partner, whereas my brothers would be like (mimics accentuated Ulster drawl) "oh jaysus, oh gaybo F-off!", (and) I'd be like "sure what about it?!"' (Male, 44, Interview 1).

Homosexuality was deemed to be a source of significant discreditation. Indicative of this, in a similar manner to which euphemisms have developed in common parlance in order to deride those experiencing mental health problems, similarly more colloquial terms for homosexuality are described as possessing significant discriminatory power and as being used to enforce this. Reference made to the common use of such language by children in particular points to a worrying trend of the adoption of discriminatory practices via the socialization process:

> 'My own kid, and we are constantly killing her over it; (singer) Justin Bieber for example; "he's gay!", "that's gay!", "this is gay!" and that's an expression now sadly... And it's the same as, you know, "that's mental"' (Male, 38, Interview 14).

Essentially, homosexuality is viewed by study participants as being seen to encompass a contradiction to social norms and values, and a failure to meet societal expectations in rural communities. Further to other personal issues homosexual individuals may face in fulfilling their identity (Higgins *et al.* 2011), participants noted that the social pressure to conform within rural communities presented considerable challenges with many outlining an anticipation that, as with those experiencing depression, such individuals would be likely to endeavour to conceal this aspect of their identity in order to avoid possible personal and familial exposure to ridicule and/or ostracism locally:

> 'For anybody, say, who was homosexual growing up in rural Ireland like, I mean that was just a really incredible thing to try and overcome, a lot of people didn't so again they weren't living how they wanted to live. I think that will contribute to a lot of depression and isolation' (Female, 37, Interview 23).

> 'Coming out, like the gay and lesbian and all of that, that's another contributing factor (to depression) because people still can't accept it... Again it's back to that everybody wants to be seen as 'normal' in inverted commas, so I have a lot of admiration for people who come out especially now' (Male, 38, Interview 14).

Supporting the findings of Corboz et al. (2008), a number of participants saw this widely held perception of discrimination towards homosexuality as a significant, stress-inducing factor in the lives of homosexual individuals in rural communities with, perhaps unsurprisingly given the course of conversation, many participants constructing a link between such stress and the development of depression:

> 'Being gay is still a massive taboo especially in rural areas... we have a high suicide rate and I think that sometimes people can't deal with this and they feel that they can't discuss it... if one of my brothers was gay I wouldn't care what people think because that's their problem, but I don't think that's the attitude of most people in the countryside, they care about what other people think' (Female, 27, Interview 16).

> 'Two lads in the family both at the age of 25 committed suicide and I believe myself like that both of them were gay in rural Ireland and just couldn't hack it... they weren't being accepted in their local, or in their families I'd say there was a problem... they must have felt alienated one way or another... there is still a stigma towards it you know, that's what happens in rural areas' (Male, 54, Interview 24).

It is crucial to note, however, that within the discussion on homosexuality participants point to a significant degree of hope in terms of the dispersion of the associated stigma. A number of interview participants noted a view that the discrimination heretofore directed towards homosexuality may be easing somewhat, in doing so highlighting this progression as evidence for the potential that exists for social change and the ultimate dissolution of profound social stigma:

> 'The same (for depression as) with being gay, I think the more you expose people, the more people are better educated and are less ignorant so they can make their own minds up and (make) informed

> decision(s) rather than being influenced by somebody else. So I think with depression the more exposure about it then you can change people's attitudes' (Female, 27, Interview 16).

> 'I'd say the progress that will be made in the next 10 to 20 years will be enormous. I mean you have the likes of this chap from U2 coming out now for (depression based) charity, (Adam) Clayton. When you have people that would speak out like that, like (hurler) Donal Óg Cusack, the gay chap, Donal, speaking out for gays and that kind of thing' (Male, 61, Interview 4).

Maintenance of Tradition/ Regeneration of Norms

Rural areas, especially when held in contrast to urban centres, are seen as strongholds for the maintenance of the traditions which form the foundations of contemporary social norms. One suggestion which may assist in providing an explanation as to why this situation persists relates to the more static nature of population mobility in such areas leading to a lack of dilution or challenge of the dominant local ideologies and thus the maintenance of the hegemonic position of enduring customs and traditions:

> 'People in rural areas, they carry the customs and traditions and all that stuff because of being in a small area. Like the area I live in hasn't expanded hugely over the years that we had all the houses built and people moving into rural areas... we didn't have a great influx of people so I would feel a lot of the old traditions are still there' (Female, 55, Interview 21).

Adding to this perceived entrenchment of essentially conservative traditions and values, interview participants also implied an understanding that such areas remained inhospitable to change characterized by an unwillingness to embrace modern thinking in relation to enduring social issues:

> 'Family traditions will be strong in rural areas as opposed to built up areas or towns or cities... There is more of a rural divide, there would be a tradition of people staying the same, they are not as open to change as we'll say urban people' (Male, 54, Interview 24).

> 'When there was work on the farm they didn't go to school, a lot of people didn't finish school, and people didn't get out, didn't get to travel and work somewhere else, they just stayed in their own community. And not saying everybody in a rural community is small-minded, but you know if you don't have an opportunity to broaden your mind and go and

> travel... I think staying in the one place tends to keep you in a closed box' (Female, 36, Interview 3).

Such was this feeling among participants that the word "country", denoting "the countryside" but said in a laboured drawl in order to express the connotation that the word implies more than its usual use, was used in some cases to describe this perceived blinkered view of society and a lethargic approach to change:

> 'My first husband was from (name of village); a real *country* area and very old-fashioned and his family were then very old-fashioned and his parents, I can't imagine ever discussing depression or things like that... they were very, very *country* you know' (Female, 43, Interview 5).
> (Note: *italics* added to denote accentuation of word)

Further to the aforementioned perceived views on homosexuality, this suggested unenlightened nature of rural dwellers reported by some participants is seen to extend across a range of issues with mention made of conservative outlooks persisting in relation to attitudes towards, for example, immigration, sexual relations outside of marriage, and eastern religions. This mixture of perceived inertia in relation to change and/or the adoption of new perspectives away from the traditional outlooks, and an apparent tendency towards conservatism, may be suggested to contribute to a somewhat claustrophobic sense of local society:

> 'I find it very kind of incestuous if you know what I mean? Everyone is all about "keep it in (name of village)" and there is that attitude I think, it's clan-ish... that they have this barrier that "this is who I am and that's what people know me as"' (Female, 27, Interview 16).

The significant value which is said to be attached to the pursuit of 'normality' and the willingness to fit within the narrow confines of acceptable social living is supplemented further by the understanding of an apparent intolerance for difference:

> 'We were living in a very kind of oppressive society you know where people felt that people couldn't be who they wanted to be and I think that contributed a lot' (Female, 37, Interview 23).

As with other features of rural life, historical culture plays a significant role as its intricacies appear to lie fresh in the collective memory and are readily recalled by interview participants. 'Anything outside the norm, regardless of what it was, was always a taboo

subject' (Female, 37, Interview 17), and this difference was seen to be met with stern resistance in order to limit the dilution of the hegemonic culture:

> '(Its) people's ideas of what is socially accepted you know as well; "you just don't behave like that, so if you do behave like that we will exclude you", "you are not in with our group or fit in"' (Female, 42, Interview 8).

> 'Years ago when people were born and if there was something just different about them that, you know, society at the time (felt) it was something wrong with them you know, it wasn't wrong with the society... And then they were put into institutes or you know, an awful lot of them, as my grandmother would tell you, were killed at birth if there was anything wrong with them and they would just put down on the birth certificate "born dead"' (Female, 41, Interview 18).

One may argue that this propensity to isolate, scapegoat, and effectively remove those who represent difference has continued to modern rural and indeed wider Irish society with the remaining significant symbols of difference continually subjected to strategies aimed at their exclusion from social life:

> 'First it was the non-nationals that were the big problem, and then gays and lesbians, and then mental health... There was some big row last night outside the restaurant and two guys were assaulted and the first thing that came up (on Facebook) was "wait until we get those foreign Cs", and it could have been fellas from down the road but straightaway it was about the foreigners... we won't blame our own but we will pick out something else; so if he's mentally ill they are going to pick that, if they are gay or lesbian or whatever then that's up for it too' (Male, 38, Interview 14).

When considered in conjunction with the above commentary in relation to sexuality and masculinity as but two examples, the importance of conformity to normality in this setting is reinforced.

Summary of 'Social Norms, Values and Expectations'

Prefaced by an understanding that a particular social code exists in rural Ireland, *'Social norms, values and expectations'* sought to provide a description of some of the key factors said by study participants to determine social life in this setting. A network of intense familial and social relations is presented as commonplace and exclusive to this environment and, with that, a sense that one's personal and family privacy is, to a certain

extent, limited. Perhaps as a reaction to this, study participants noted that behaviour is seen to be directed and/or curtailed to fall within a defined conservative ideology which places the emphasis upon the active portrayal of a strong, stoic and prosperous individual and familial image, reservation, and conformance to traditional gender roles and sexual identities. Such attribution, as well as explicit direction to do so, serve to maintain and regenerate adherence to such traditional lifestyles.

Cognisant of this restrictive social environment, in terms of the stigmatisation of depression, the condition is seen to compromise a number of these core identity and behavioural elements of rural society and in doing so, one may argue, provide the legitimation for the othering of those affected and with that the implementation of stigmatising attitudes and practices.

Suicide

Within the *'Theoretical Concepts'* chapter above, mention is made of Goffman's notion of courtesy stigma in which the stigma attached to an individual can also be attached to those closely associated with them. Taking the idea underlining this notion, one may argue that, based upon the contributions of study participants, in many ways depression is in receipt of a courtesy stigma via its close association with suicide.

'Suicide' in this instance refers to this relationship between the stigmas of the act of suicide and the experiencing of depression. This aspect is discussed within the following sections; *'Suicide and the Social Environment'*, *'Association with Depression'*, and *'Developing Perspectives'*.

In perhaps the most difficult aspect of the interview process, while not an issue placed directly before any interview participant for discussion, a considerable number of participants chose to speak about their experience of, or exposure to suicide in their families and in their communities. A number of participants outlined details of their own personal stories of survival together with those of the loss of close relatives and friends. Typically, such discussions arose in the form of outlining the similarities which exist between the heavily interlinked discourses of suicide and depression, and also the subject

of stigmatising social pressures acting towards the maintenance of secrecy in relation to each:

> 'It's (depression) a bit like the suicide, nobody really wants to say that somebody died by suicide, they just want to say that they died and that is it' (Female, 59, Interview 12).

> '(Depression) is not spoken about enough and (there) is not enough programmes on the telly and it's not spoken about, it's all a bit hush-hush. And the thing of suicide, it's such an awful thing to happen that nobody wants to talk about it... But in reality it happens a lot and we need to start talking about it more' (Female, 36, Interview 3).

Suicide is described as a social issue which has until recently maintained a presence simmering below the surface of social discussion in rural communities, perhaps held in this position by the silencing pressures outlined here which have their origins within and act to shape social expectations. This submerged nature of the issue is a source of concern and confusion for participants given the gravity and apparent ubiquitous nature of suicide within rural communities. It is suggested that 'everybody tends to know somebody now who has committed suicide' (Female, 61, Interview 10) with many participants evidently at the point of exasperation upon attempting to comprehend the numbers touched by suicide both within their own families and communities and across rural and broader Irish society, and also due to 'a sense of people not knowing what to do about it' (Female, 61, Interview 10):

> 'When I say I'm from XXXX, XXXX has one of the highest suicide rates in Ireland. We've had a huge number of instances of people committing suicide (whispers) in the area, a lot of younger people as well as older people you know. It just amazes me sometimes the type of people that actually commit suicide' (Male, 54, Interview 24).

> 'You are seeing an increase in suicide. Particularly in my own home town... there is a graveyard there which is called "Suicide Row", 35 or 36 young men who have taken their own lives in the last 10 years... and they are all buried in one area' (Male, 40, Interview 22).

Naturally, participants noted a considerable fear of suicide and in particular a fear of having to cope with its spectre within their own family or network of close personal connections:

> 'I suppose with all the talk that has been on the radio about the need to listen to your children and things like that then maybe they (parents) are becoming more aware of it, and people are scared about the suicide thing they definitely are' (Female, 61, Interview 10).

In somewhat reactionary fashion, it appears from the interview data that a precipice has been reached upon which this previously buried subject has been forced to surface and assume a position of concern among the collective consciousness as its occurrence becomes more widespread, or, perhaps, the sheer weight of the devastation caused has become a load which can no longer be borne silently. The apparent increase in instances of suicide across the country and a growing propensity for those affected in a personal or professional capacity to speak out is leading to the promotion of discussion of the topic with a view to addressing its causes and contributing factors:

> 'There is a lot of discussion around suicide in young men unfortunately... these youngsters have been doing this for a good number of years, as have adults, but it's just that that it's making news now because the statistics are being drawn up that there is roughly 900 suicides a year... even that 900 figure is a disputed figure... coroners in the country, they are under fierce pressure not to record suicide death' (Male, 61, Interview 4).

> 'I think of everyone that his (brother) death (by suicide) affected, so definitely all of those people are changing how they think about it, there is a kind of ripple effect from it. Hopefully people are changing. I definitely think it can't be ignored, the suicide rate in the country, that's obviously going to change how people are thinking' (Female, 37, Interview 23).

Suicide and the Social Environment

Overall, the interview participants who discussed suicide provided sufficient evidence to suggest an understanding of the implications of social and environmental factors upon the mental health and wellbeing of individuals and thus suicide, with the link between these latter aspects mostly implicit within such conversations.

> 'We were talking about the chap that attempted suicide, and it was an unsuccessful attempt, and they reckon part of it was because he was working long hours at night and he was by himself listening to the radio and he was a truck driver and he was by himself the whole time even at weekends' (Male, 44, Interview 1).

> 'There is a high suicide rate in (name of village) over the years with especially young men, and like the contributing factors again are unemployment you know, boredom, loss of self-esteem, marriage breakup, all the indicators are there if you know which is sad' (Male, 38, Interview 14).

Through a number of discussions on varying topics of social salience, participants offered suggestions which forged linkages between how the social environment, and in particular the dominant aspects of culture within this environment, may be conspiring to promote a suicidogenic society. A particular emphasis was placed upon the pressure being placed upon persons to conform to the norms and meet the demands and expectations of contemporary rural and broader Irish society:

> 'My own boss committed suicide and you know, there was no evidence to us... He had changed behaviour but it was supposed to be the worry and strain of the job... then another colleague's brother committed suicide only about a month and a half ago... to the normal person they didn't seem to have any sort of serious mental problems, that it would have been, how will I say, created by the environment at the moment' (Female, 61, Interview 10).

> 'I know that there would be a number of suicides in (name of village) because too much pressure was put on the students. I also know that particularly in disadvantaged estates we have had seven suicides in the last two or three years and that goes back to things like drugs' (Male, 40, Interview 22).

One participant spoke of a relatively new phenomenon borne itself from what has been described as a perhaps forced but still more open discussion of suicide. While contemplating its merits or otherwise, the participant stated her perception of a widely held view and concern that societal thought on this issue has swung dramatically from the extremes of secrecy towards the near glorification of such acts:

> 'There tends to be this "show" aspect of the funerals... putting up memorials and things like that. Young people want that kind of thing. Well sorry that's what I observed, that people want to kind of, as it were, "normalise" it probably a bit more than older people would have done... Older persons would be more focused on you know, "why did he do that to his parents?"... there would be a lack of understanding for the person that actually did it or attempted to do it or whatever the situation was, it was more questioning the chaos that they caused' (Female, 61, Interview 10).

Association with Depression

The majority of interview participants who spoke of suicide noted its implicit association with depression outlining how others in the community 'automatically attach' (Male, 38, Interview 14) the two. Concern was expressed towards the potential of having to deal with either circumstance, both circumstances, or dealing with suicide due to an inability to sufficiently accommodate instances of depression in those within one's network of care and concern:

> 'The link of depression and suicide, it is really good that it is known and shared but it probably brings an added concern to people because they are saying, "might I have to deal with "that" (suicide)?" How would they deal with "that"? And people don't know how to deal with "that"!' (Male, 61, Interview 9).

A small number of participants offered a differing perspective, intimating perhaps a perception of a lack of knowledge of the link between these factors within the broader community or, perhaps due to the stigma attached, a tendency to ignore depression as a possible underlying cause of such actions:

> 'When people do die from suicide it's kind of like "oh he killed himself" or something like that... but they don't link depression with suicide. They would just tend to blame things like "oh he lost his job" or "she broke up with her husband" or that sort of thing... Of the people that I would have known who died from suicide I don't think they would have suffered from depression but I don't know I suppose...' (Female, 35, Interview 20).

It is suggested that both depression and suicide are also linked due to the high level of stigma attached to each. Each element is accepted to hold a high level of individual stigmatization, with each element's association with the other; that is the stigma of each element operating in a courtesy stigma manner, contributing to the sum of the overall stigma of each. As suggested, then, part of the explanation for the persistence of the stigma relating to depression lies in its association with the possible eventuality of suicide:

> 'People are more aware of the link between depression and suicide and those kinds of things and I think that, you kind of don't really want to be in around that... So there is a kind of distance thing that happens because of that, those kind of fears' (Male, 61, Interview 9).

'After my brother died (by suicide)... I came back to work and a colleague came in and said "God I was terrible sorry to hear about your brother and it's a very sad time for you all"... then we got chatting about a work placement and she said "Joe Bloggs is looking for placement on the scheme"... and she said "sure that lad tried to do away with himself, he's not all there!". So even though she had just spoken to me and just offered sympathies and the whole lot... I don't think she had even copped what she said... So that's kind of where people are at' (Female, 37, Interview 23).

Developing Perspectives?

A number of interview participants sought to suggest that views of a stigmatising nature perceived to be widely held in relation to suicide in rural Ireland were in the process of being reviewed with perspectives developing significantly compared to previous generations. Hope was expressed that people, young people in particular, in this setting were becoming more adept at discussing such previously sensitive issues. As suggested above, however, this greater perceived tendency to openly discuss suicide may be seen as the outcome of the imposition of the circumstance with the unfortunate familiarity with such events providing the impetus for more frequent contemplation about suicide in a repeated process of attempting to understand its outcomes:

'They speak very freely and open about it. And they are very aware of it, and they are very much there to help any of their friends who were down, which I think is excellent because if I was 18 or 19... I wouldn't know what to have done. It would have been a big kind of "brush it under the carpet and forget about it" thing. While now I do feel the younger generation, and I think it is becoming, although it is a sad thing to say, more common, so I think they are being made more aware of it' (Female, 41, Interview 18).

'My brother, he actually committed suicide, he was 44 and my parents were both born in the thirties so for them depression was a weakness you know, and it only happened to some people, and it ran in families, and it was laziness, and all that. So when they were confronted with that in our family, and there was no history of it, they actually had to look at it full on and say "God actually he's not well, he's actually not well and it's nothing to do with being mad..." And I think I saw that shift you know... people are looking at it differently and they are deciding that you need to reach out to these people' (Female, 37, Interview 23) .

Summary of 'Suicide'

The immense fear towards, and concern associated with the avoidance of contact with suicide may be seen as a significant driver of the stigmatisation of depression as those within this sample of rural inhabitants are seen to make the direct linkage between depression and suicide and, crucially, view others to do likewise. Acknowledging the growing numbers of individuals taking their own lives across the country, and the apparent high incidence within rural Ireland, again focussing mainly upon men, study participants invariably looked to the social environment for the causes of this growing public health issue.

Pointing to a hierarchy of concern, though not explicitly stated by participants, the frequent unprompted discussion of suicide within the broader context of depression must be seen as alluding to a simmering concern that depression could eventually lead to an individual or family coming to deal with suicide in their midst. An outcome of obvious immense consequence, one may also argue that due to the frequent mention of the stigmatisation associated with suicide, driven to a large degree by the same social norms, values and expectations as listed above and also those discussed within *'The Role of the Catholic Church'* below, it was also viewed as the harbinger of a sustained family-focused stigmatisation. Though said to be improving, the typical response to this, in common with other sensitive issues, was seen predominantly as movement towards secrecy with, due to their association, the discussion of depression included under this veil.

The Role of the Mental Institutions

> 'My recollection of people that were depressed, to be honest they were nearly always just put into an institution eventually, including my own auntie. And yes they got this electric shock and they did all that sort of thing in St. XXXX's... (She was) locked away, and when I mean locked away I mean physically locked away' (Female 59, Interview 12).

'The Role of the Mental Institutions' refers not necessarily only to the role played in the actual treatment of patients within mental health care settings of which some mention is made, but more to the symbolic characteristics and status perceived to be attached to mental health institutions in rural Ireland as discussed by the study sample.

As suggested previously, based upon the interview data one may suggest that mental health care facilities are a considerable contributor towards the stigma associated with depression. This stigma is seen to manifest through a number of aspects associated with such facilities including incarceration, the proliferation of medical power, the structure of the language employed in their discussion, their physical settings and aesthetic qualities, and the secrecy which persists in relation to what transpires 'behind the walls' (Raftery 2011). Each of these aspects will now be discussed.

Incarceration

> 'It seemed to be more about taking people away out of society I think myself you know; "what society won't know won't trouble it so we'll lock you away in there"' (Female, 37, Interview 19).

> 'People that are going to hospital now are not going in for as long as they were one-time, I mean people went in before and the key was turned and that was it...' (Male, 61, Interview 4).

Removed from the ideals of therapeutic treatment in an open community setting, mental health care facilities continue to represent a sustained source of fear among those in rural Ireland according to the current sample. A view of mental institutions as being akin to correctional facilities is put forward with the only considered reason for possible engagement with such institutions being, as a last resort, detention against one's expressed will. The fear of the institution and the incarceration it represented appeared to permeate through the views offered by participants:

> 'I had a preconceived idea that, that I was in an asylum, and that you are locked away, and that you won't be allowed to leave again like what happened there for years, and that was only a few years ago...' (Female, 33, Interview 13).

> 'My ex-husband would have said at the time when I spoke to him about it (his depression), when I asked him to go and see a doctor it was like; "no because they will lock me up and throw the key away!" You know there was a fear of that do you know, that they would be put away and hidden and they would never be heard of again' (Female, 37, Interview 17).

Further to the association with incarceration, some participants, reflecting upon the history of mental institutions, supplemented this point with a recognition of the disdain which those

who were institutionalized were treated even, and in some cases particularly, by their own family. This element may be seen to add even greater associations of stigma as the family, noted above as the most important unit within rural society, were deemed complicit in the extension of the power of the institution, thus further stigmatizing mental illness which became seen as holding a sufficient level of social unacceptability so as to break intimate familial bonds and the accompanying responsibilities:

> 'There is that stigma going back to the way people were sentenced to mental hospitals... The way people dealt with mental issues before was like "ah sure Johnny is gone to the mental asylum, he's safe there", you know "he'll be in (name of town in which mental hospital is based) he'll be grand, he's not bothering us now". And I think over time people forgot about them you know' (Male, 40, Interview 22).

> 'That program that was on last year about people who had been institutionalised and who have been put in involuntarily into these institutions all across the country like in St. XXXX's and that kind of thing, they were just put out of the way in a lot of cases because they were a nuisance and because they (families) were ashamed of them and it all stems from that' (Female, 37, Interview 23).

Medical Power

Recalling Foucaultian theory in relation to the power of the medical profession (Foucault 1963), similarly to a number of themes discussed, the weight of history bears heavily upon the formulation of contemporary perceptions of mental health facilities. Stories were recounted of the physical segregation of family members from the community within such settings in a time when the power of the medical profession was such that the questioning of such orders was forbidden:

> 'You don't question, I mean "the men in white coats syndrome" and all that, you don't question... when my father was put in, I mean my mother never questioned, it was like "the doctor said he has to go" and that was that. And everybody on our street knew "oh he's gone into the mental institution", you know "there is something seriously wrong with him". And nobody questioned it then you know, the doctors put him in there for a reason, so obviously the doctor is right' (Female, 37, Interview 19).

Abuse of such power was seen as rife. Pointing towards the complex symbolic relationship rural communities hold with institutionalization, and towards their historical contribution to the traditional mechanisms of social control, a number of participants

referred to historical instances in which institutions were used to accommodate individuals for whom forced destitution may have been the only other available option; victims of then culturally accepted practices in which vulnerability was exploited:

> 'A lot of people were shoved in there after signing over farms to their sons and daughters... They got rid of them that way. At that time you were open for bribery to get a doctor to sign them into (name of town in which institution situated). Then they would have the land and they wouldn't have the thing of looking after them at all. So that's long gone but they would associate (name of town in which institution situated) with that' (Male, 73, Interview 15).

"The Madhouse" - Stigma of the Place

Feeding on from the theme of incarceration above, '"*The Madhouse" – Stigma of the Place'* refers firstly to the way in which mental hospitals were referred to in wholly negative terms, but also to the ambiguity which is perceived to persist around the actual nature of treatment and care provided in mental health care settings. Upon discussion of 'the mental institution', the majority of study participants reported how such facilities were, and to a great extent remain perceived as settings in which persons are detained away from the community due to their disorderly behaviour:

> '"The madhouses" and all these things as well, I think these things have been passed on down through generations as well, if someone's behaviour isn't what you want them to be you will threaten them with "oh I will sign you in" or "I would bring you out that road (to the mental hospital/asylum)"' (Female, 30, Interview 26).

> 'Going back to years and years ago when people with depression were institutionalized and they weren't even institutionalized for to help them get better and feel better, they were institutionalized because it was like "go away", "you are an issue, you are a problem". And you know a lot of them were institutionalized for quite some time, so maybe that is something that has just seeped through the generations' (Female, 27, Interview 16).

Such facilities were viewed as, in effect, spaces in which deviance could be contained and provided a tangible and real source of threat which acted to ensure the concealment of deviant behaviours.

The powerful symbolism held by mental health care facilities is said to be enhanced by their physical presentation. The aesthetics of the environment in which such facilities are based appear to contribute to the theme of incarceration and the inducement of a sense of discomfort in participants. According to participants, the architecture and positioning of these units does little to improve the image of the mental hospital with rich descriptions offered of imposing, ageing, desolate, high-walled buildings located in discreet, isolated areas, often geographically removed from the population centres, with the intimation that such vistas alone induce a sense of fear and menace:

> 'It's a big grey building, a horrible looking building, with stone walls and it's still open actually' (Male, 73, Interview 15).

> 'I think the Central Mental Hospital in Dublin is right next to the prison, I mean personally I don't think that that is right, not at all, because it doesn't portray the right attitude towards people with mental illness...' (Female, 27, Interview 16).

> 'They would say you know "I think he's downstairs in the hospital", that means he's in the area where people get treatment for mental problems you know, and that would be kind of whispered you know... (whispers) "He's downstairs, it's not good you know", that's the attitude they would have' (Male, 54, Interview 24).

Further to the commentary on *'The Use of Euphemisms'* in the previous chapter, the ambiguity associated with these settings appears to commence even from how they are referred to conversationally within rural communities.

> '"Did you hear that so-and-so was inside in the unit?"' (Male, 61, Interview 4).

Such facilities, one may suggest due to the nature of the fear and social discomfort in discussing anything within the subject area of mental illness, were seldom if ever referred to using their official title with even the words 'psychiatric' or 'hospital' or reference to medical treatment of any description described as continually absent from conversations discussing same:

> 'People are inclined to say that someone "went to PPPP" which is the mental hospital here, yeah if you "went to PPPP" oh God, they don't want to know, they don't want to know... it was just "PPPP", there wouldn't be

any mention of the hospital or anything just "PPPP"' (Male, 73, Interview 15)
(Note: 'PPPP' denotes name of county town where facility is based).

'They still have these names, you know, like eh "the Loon house" and those kind of things and people still use terms like that...' (Female, 27, Interview 16).

'74B was the ward in the regional (hospital)... "the loopys go to 74B" you know. It was like "take him to 74B" you know, when you are in school it was like "oh she was in 74B"... when I was at school and it was a slag then, "you're mad you're going to 74B", and obviously that is still going on... if u were in 74B u were loopy and there was no hope for you' (Female, 43, Interview 7).

Other pseudonyms include those derived from, for example, the distinctive appearance of the building itself or an abbreviated version of the name of the ward which, as discussed in greater detail within the commentary on *'The Role of the Catholic Church'* below, was typically associated with a theological figure, with each of these discussed in an almost code-like manner of secrecy. With this barrier of concealment present at such a primary level, it is unsurprising that participants spoke about the perception that the general community had little comprehension of what exactly transpired within such facilities. Many recalled that attempts to gain a better understanding through seeking information were frequently met with silence or the dismissal of the query serving only to add to the sense of mystery surrounding the activities which took place there:

'They wouldn't talk about it, it was a taboo subject yeah, it was like sort of; "she's in there being looked after, don't talk about it!"' (Female 59, Interview 12).

'My mother has depression...she ended up in, I don't know I suppose it was called a "mental sanatorium" or whatever it was called at the time. I have very little memories of us just going to see her and seeing her at a window, and that was it... it wasn't spoken about, it was "your mother is sick!" (said firmly), or "your mother is in hospital"... It was never really talked about so we never really knew what exactly the problem was... it was never named as depression but I as an adult now know that yes it was depression' (Female, 42, Interview 8).

Invariably, with secrecy surrounding proceedings in such institutions, it is unsurprising that the treatment to be gained in such places is also noted to be discussed in euphemistic terms:

> 'I know some people suffering from depression and they call them "oh they are crazy"... It's still more in rural Ireland, obviously down here in the country it's probably still a big stigma whereas in the cities maybe people don't you know. Lots of my friends live in America and when they have it they just have their therapists and nobody looks bad or down on them, whereas it's "shrink" here still and you know, "you need someone to help you deal with the inside of your head"' (Female, 41, Interview 18).

Suspension of Convention

While this lack of clarity persisted, it was definitively understood that such facilities were not to be viewed in a similar manner to other tertiary care units. Thus, patients there were not seen to be afforded the same social conventions which would be expected for those in wards or hospitals catering for the treatment of somatic illness:

> 'I wasn't jealous but (pauses) I was questioning you know? He (neighbour) had wall-to-wall cards because he had a triple bypass... but you get sick from depression and people don't seem to know what to do... I got no messages of goodwill, I got no get-well messages or bouquets of flowers, I might as well have been in Mountjoy jail... I spent six months in St. XXXX's hospital and I could have been anywhere, I might as well have been on Mars' (Male, 61, Interview 4).

> 'It was "the madhouse" and things like that, and you know it was deemed to be nearly like hell... (With) "lunatics" and you know all those kind of words which give off awful messages to you... I mean you could go to (name of hospital) to have your legs fixed and it was never "the madhouse"' (Female, 60, Interview 11).

The culmination of these factors suggest that mental health care settings in their current form, but based to a significant degree upon their historical standing and associations, represent a significant factor in relation to how depression is perceived in rural Ireland. The significant ambiguity which exists in relation to some of the key features pertaining to mental health care settings can be seen to explain to some extent why the very mention of such facilities appears to add further gravity to one's experience of depression:

> 'St. QQQQ's... it's a big building so for years growing up it was... if your mental you end up in "the building", and I was there (giggles) you know! I ended up in "the building!"... everybody would know "the building"... it's all over the place, all over the county, "if you end up in the building" like... so people would have been laughing at it or taking the piss out of it or not seeing it for what it really was... I just thought "oh my god I'm trapped in this place, I really am trapped!" And I thought I'd have to have a piece of paper stamped to say that you're okay to leave, (giggles), that was my view of it... I never knew exactly what happens up there... so I said "well I want to get out of here now!" Because (of) this feeling of being trapped' (Female, 33, Interview 13). (Note: colloquial terms altered to ensure confidentiality)

> 'I had to go (whispers) and meet one of the psychiatrists in St. UUUU's. I do remember sitting there, and for black sense of humour, I said to myself "did I think I'd be sitting here with those horrible green walls waiting to see a psychiatrist at age 31?!" (laughs)... They were all depressing places to be and I wouldn't blame people for having (a fear of the place). And once you went in you weren't going to come out and things were done against your will, they were of course terribly oppressive places' (Female, 37, Interview 25).

Further, and also potentially contributing to this view of increased gravity, it is suggested that others in the community were viewed as being somewhat perturbed by mention of attendance to such a mental health care settings with the emergence of this fact acting almost as a trigger for social disengagement:

> 'Depression is still very much a taboo... it's when people maybe have to go into an institution to get treated that that becomes, nobody really wants to know about that' (Female 59, Interview 12).

> 'You were presumed you were mad... you were a lunatic or "he's not right in the head" that kind of thing you know what I mean, "you've to be careful with him" that kind of thing' (Female, 37, Interview 19).

Summary of 'The Role of the Mental Institutions'

'The Role of the Mental Institutions' outlined the symbolic role played by mental health care facilities within the stigmatisation of depression. Drenched in historical references, invariably throughout the data such facilities were noted as holding enormous negative symbolic power and attributed with almost medieval-period qualities focusing upon ideas of the forcible removal from society of social deviants, and long-term incarceration. These notions were seen to be supplemented by the traditional hegemony of medical power

which served to reinforce the undertones of social control. The distinct physical attributes of what participants viewed to be the common perception of what such facilities resembled, together with a rich lexicon of euphemisms which served mainly to add to the mystifying and secretive qualities of these places, were noted as key elements to the proliferation of the ultimately hostile narrative of these venues of supposed therapeutic concern.

The Role of the Catholic Church

> 'I don't think we can underestimate the influence of the Church and it being moved away from (is having) for the understanding of depression and mental illness' (Female, 37, Interview 25).

In attempting to understand the genesis of the stigma which persists towards depression as detailed by this rural Irish sample, a consistent theme relating to the role of the Catholic Church in Ireland in its many guises was offered by study participants. Discussion of the Catholic Church's role in depression stigma proliferation is offered under the following categories: *'Evolving Role of the Catholic Church in Rural Ireland'*, *'The Church's Role in Socialisation'*, *'Spirituality'*, *'Shame'*, and *'Figurative Associations'*.

Evolving Role of the Catholic Church in Rural Ireland

Participants acknowledged that traditionally the Catholic Church held the utmost power in rural Irish communities having secured the position of holding outright moral authority together with a commanding share of access to sources of power and prestige in each community, in many cases defining what each of these elements were. This potent mixture of power and influence was seen to mould the direction of the hearts, minds, and thus behaviours of those without such authority and indeed those seeking to attain position:

> 'People wanted to be accepted by the Church and the priests and it was a hierarchical thing again that if you were well in with the priests you had status in the community... And the more you are able to pay the higher up the ladder you were' (Male, 54, Interview 24).

Upon discussion of the role of religion in rural Ireland, and in particular in relation to the proliferation of stigma towards depression, a number of participants explained that the

Church still maintains a considerable foothold in rural Irish life. These interview participants saw the Church as a stable feature within most rural Irish communities with its moral teachings, as discussed in the commentary of *'Social Norms, Values and Expectations'* above, seen as providing the foundations upon which the norms and expectations of rural living remain based, while its physical presence within every village or town was seen as one of the focal points of social activity:

> 'Catholicism is still very, very strong in the rural communities... the Church would still be seen as an anchor in those communities. I would be even very surprised to see the young people that still go to church regularly every Sunday... (compared) to Dublin City or Cork City where 10 or 20% of the population go to mass, so the Church still has a strong focus, and they still have that sense of community and sense of parish' (Male, 40, Interview 22).

Based upon the views and intimations of the majority of interview participants however, while maintaining this foothold, the Catholic Church is mostly viewed as an institution in significant decline. Most often speaking in the past tense, the Church is discussed throughout the interview data with participants giving detailed accounts of the typical rural social conventions of the recent past which most often centred upon Sunday mass, the content of which was often secondary to the social occasion which it presented on a weekly basis. The loss of this forum for interaction among possibly disparate rural communities is lamented but considered inevitable:

> 'A place for socialising was outside the church in rural Ireland... you would have a load of people chatting together catching up with what was going on if only it was about the weather or whatever... it's not happening as much anyway and the young people aren't buying into that as much at all so I'd say in 20 or 30 years again I can't see very much of that happening' (Male, 54, Interview 24).

Whereas once one may have expected a steadfast defence of the institution from such a rural sample, the overwhelming tone in relation to the role of the Catholic Church in social affairs is definitively critical. The following sections offer an insight into what may be viewed as a damning legacy which has, in many respects according to the views of study participants, served to shape the stigma towards depression under examination.

Church's Role in Socialization

From the moral teachings pertaining to gender roles, sexuality, and family values, to the patronage of the Church in the formal State education system, participants recounted how culturally instilled Catholic doctrine passed on through generations, continues to stealthily determine considerable aspects of the lives of those under both its direct and indirect influence. Many participants voiced open criticism as to whether such indoctrination has served for the betterment of rural Irish society:

> 'The Catholic Church is where a lot of the norms would have come from... that's where the family values would have been developed... Like I would say an awful lot of people who would have had a member in their family with depression the first person that they would have spoken to years ago would have been their priest' (Female, 37, Interview 17).

> 'It comes back to the Church and the defined roles that "this is a man, and this is a woman, and this is your role, and this is your role". I think the Church has a lot to answer for myself, yes I do...' (Female, 27, Interview 16).

Catholic teaching was seen by many as instilling a rigid social order upon Irish society which bound the faithful to uphold Church-led notions of decency and correct behaviour. This order, which may be seen to have promoted a sense of fear and intolerance towards difference, participants noted as being held in place by a social pressure which originated from the institution but was reinforced through the beliefs emanating from indoctrinated followers:

> 'It would have come from the real old Catholic Ireland thing about anybody that's (different)... I mean even if you look at the time when people had Down Syndrome or one of those special needs as well, they very much had been put in a little box in the corner... that it was a flaw you know. And I think that sticks you know, I think if it's stuck then in the parishioners or the people who went to Church, in the people who listen to that, that would be what they'll be bringing back to their families and passing down' (Female, 37, Interview 17).

Spirituality

Mirroring commentary within the established literature, many interview participants made reference to the demonologic nature with which mental illness and depression was, and in some cases remains conceptualised with the Church seen as playing a pivotal role in the

proliferation of such notions. Reference was made by some participants to the weight of generations of Church teaching often bound in placing a particular emphasis upon the role of spirituality and the supernatural, centred upon concepts of good, evil and moral corruption, as forms of explanation for the behaviour of those who strayed from the confines of the dominant social and moral order. Interview participants noted how this rhetoric had survived to penetrate contemporary parlance and, while weakened, was suggested to account in some way towards the ill treatment of depression in a rural Irish society steeped in this belief system:

> 'It comes from the Church again like, and wasn't it always the way that you know; "cast out the demons!", wasn't that what was said over the years?... that is probably where that emanated from, that's actually quite true when you think about it...' (Male, 38, Interview 14).

> 'If you go way back, if there was a person and there was something wrong, "the witches" were acting and "the witches" were meant to have taken you over... if there was something wrong with you many years ago they would have said that, that was God punishing you and the devils were around, I suppose that's going way, way back, but I suppose maybe it's still caught on' (Female, 41, Interview 18).

As suggested above, beyond the notion of the manifestation of malevolent forces as the cause of depression, others also noted the scripture-based suggestion that it was merely a self-indulgence; a sin which could be atoned for via a greater dedication to living a life of devotion. Depression, then, was at times suggested to be seen as the unfortunate consequence of a life in which the worship of a deity or the preparation for salvation was absent:

> 'I wouldn't personally, but I think that other people might think that this lack of spirituality would, that they are not worshipping or they don't have... I would say that other people would think that if people went to church and they prayed that it would take their mind off it or that they would have some kind of goal' (Female, 27, Interview 16).

Interestingly, these sentiments from the interview sample are not shared within the survey data in which a suggestion that most people would view those experiencing depression as guilty of some form of immorality was comprehensively rejected with the overwhelming majority of survey respondents (88.5%) disagreeing to some extent with a supplied statement containing sentiments to this effect.

Shame

As a result of the pervasiveness of the moral teachings discussed above which could be understood to promote, in the very least, a lack of understanding of difference, many participants suggested a culture of shame has been one significant aspect of the legacy of the Catholic Church's era of social domination:

> 'Shame, it is so rooted in the Irish mindset that it is only now we are starting to break away from it, but those attitudes are still ingrained, even if you detach or put the Church to one side, it's just there now and it's ingrained, it's in our culture' (Female, 27, Interview 16).

In relation to depression, it is suggested that this shame may actually serve to contribute to the condition itself by imposing further feelings of stigma-based guilt upon the person experiencing the condition as a result of being deemed to be in contravention of an established moral code:

> 'The answer if you were in any pain or anything was to offer it up to God. Was it punishment for your sins?... I found myself saying that, "did I do something? What did I do to deserve this (depression)?"... "Am I being punished for something?" Or just the terrible thing of "it's all part of the plan" and that whole ethos of "you are either being punished for something or you are being taught a lesson"... "Did I sin? Am I a bad person that I brought this on myself?"... Those Catholic things were coming back into my brain and it's like; "am I being punished?" Because the Church teaches that very much: cause and effect' (Female, 37, Interview 25).

Further to the discussion of *'Social Norms, Values and Expectations'* above, such views may also be seen to contribute to an understanding as to how depression has arrived upon assuming a position of social deviance with notions of sin contrary to the dominant religious based conservative ideology, said to remain in rural communities.

Church Response to Suicide

> 'The Church would have played a big part because suicide was only decriminalised in what, like 1993 or something?... People feared the Church and didn't want the parish priest or whoever thinking (less of them)... So thank God that kind of fear is gone of the Church... People aren't afraid to talk anymore, and even with things that were uncomfortable talk about like feelings and emotions' (Female, 37, Interview 23).

Further to the *'Association with Depression'* section within the discussion of *'Suicide'* above, perhaps the most frequent response in relation to shame emanating from the influence of the Catholic Church and its perceived position in relation to depression interestingly relates to the history of the extraordinary treatment of suicide by clergy in communities across the country. Some participants recalled how suicide was treated as an act driven by immorality; the product of a corrupted upbringing, a personal or family failing, was in defiance of God's wishes, and thus legitimated punishment. 'Committing suicide', a phrase with both religious and legal connotations, has also emerged in common parlance and was frequently mentioned to be understood as a matter in which the actions of the Church had served to create a considerable moral and social statement of disapproval devoid of understanding:

> 'Suicide, which is closely linked to depression you know, from the Church point of view it was associated with shame and people up until very recently weren't buried on consecrated ground' (Female, 37, Interview 25).

> 'In the parish that I'm living in there was a plot outside the graveyard for people who had done away with themselves and that would still be remembered I suppose by the older people and it would be passed on in families and stuff like that... I know that happened in our area, I have heard that been talked about' (Male, 54, Interview 24).

The reported practice of refusing the burial of those who had taken their own lives among their deceased family within a consecrated graveyard appears as a most enduring and evocative collective memory. Participants recounted the implications of such actions of physical segregation and discrimination after death as amounting to the imposition of immense shame and decreased social standing upon the deceased person primarily, but also upon their family who were also implicated as near accomplices in such deviant behaviour in line with notions of courtesy stigma. Mindful of this, and of the established linkage between the two, the shame of suicide was felt by participants to have considerable consequences for those experiencing depression also:

> 'You can't honestly talk about depression without mentioning suicide. And suicide was such a, I mean the Catholic Church were so pervasive here and put such a shame on it, I mean the person was ostracised even after death in that they weren't allowed to be buried with their loved ones on consecrated ground and they were going to hell and all that. I mean the dread of the shame of someone committing suicide would obviously

> lead someone who is thinking about it who was obviously depressed not speaking about it... I think there is a strong link between the two...' (Female, 37, Interview 25).

Since rescinded by Church authorities as acceptable practice (Kelleher 1996), a fact some contributors remained unsure of, the legacy of such exceptional behaviour and of the moral and philosophical teaching which accompanied and guided such acts have survived and reside within the culture of shame and stigma persistent in modern Ireland.

Mindful of this legacy, some participants nonetheless outlined the progress which had been made in thinking in this regard:

> 'Most people would see it as sad, they might see it as a failure but not as a moral failure... As a weakness, but not really a moral weakness... understanding of it has evolved a little bit you know, since not being buried in cemeteries and such... While it's a topic that's good to gossip about in that it's 'juicy' to a certain extent... suicide is treated as really sad and not "why wouldn't you think of the family and such?"... It's, "isn't that awful" not "what a prick!" Because I personally, when I was a lot younger, used to think of suicide has being really, really selfish' (Male, 25, Interview 2).

Figurative Associations

The perceived link between depression and indeed other forms of mental illness with spirituality and the supernatural may be seen to be given further credence by the noted association of the Church with their treatment in State-run institutions. Though rarely an explicitly made point by participants, but instead a consistently occurring aspect during the course of conversation reflected upon in passing, Church-based associations were frequent as discussion of treatment facilities were littered with religious references, in particular in relation to the many institutions and wards which had been named in honour of Catholic saints. As noted in extracts throughout the sections above, interview participants frequently referred to mental hospitals or mental health wards using regional slang or abbreviated terms with such abbreviations often taking the form of the name of the saint after whom these facilities were named:

> 'Here in County XXXX, I would be thinking towards St. DDDD's hospital and I'm sure, I mean St. DDDD's would go down like a lead balloon to

> anybody in any county you know, like St. TTTT's hospital or any of the other ones...' (Female, 60, Interview 11).

Other such associations are also apparent in the data. Mentioned above, a second consistent example relates to participants recounting how local reaction to depression amongst those in rural communities manifests with a suggestion, however unintentional, that, perhaps due to the supposedly spiritual nature of the condition, or indeed due to the gravity associated with mental illness, an affected person should be entrusted to the care of God in order to achieve recovery:

> 'It's very easy to dismiss people or their views or opinions or actions on the basis of "sure they're depressed, God help them"' (Female, 43, Interview 7).

> 'It will be like (whispers) "oh God love them, they are gone a bit touched and they're off to St. KKKK's"' (Male, 73, Interview 15).

Such traditional phraseology may merely be conceived as an inconsequential aspect of common language typical to rural areas and elsewhere, and likely to be equally employed within the context of the requirement for treatment of somatic illness. However, one may argue that the noted frequency of the inclusion of such terms in the instance of depression, often in combination with a sense of exasperation which was detectable in the tone with which they were uttered, may lead one to believe that reversion to the supernatural explanations promulgated by religious institutions historically reflects a level of attachment to a belief that such conditions hold some level of paranormal intervention, and thus a lack of contemporary understanding of such conditions and modern treatment methods. One could further argue that the figurative associations present in mental health care facilities may be acting to support this viewpoint, or in the least, are assisting in the maintenance of such associations.

Summary of 'The Role of the Catholic Church'

According to study participants, the Catholic Church has made a significant contribution, both directly and indirectly, towards the proliferation of the stigmatisation of depression. Noted as an institution which, while in significant decline, still maintains a foothold within rural communities across the country, the dominance of the Church historically was seen to exert significant influence upon the socialisation of generations of Irish people with the

conservative ideology it espoused evident within the traditions, norms and values of subsequent generations. Perhaps the most noted aspect of the Church's influence upon stigma is indirect in nature with, one may argue, the inherent Church focus upon spirituality contributing to, and combining with folklore-based supernatural explanations of depression and wider mental illness to inhibit greater understanding and facilitate the continuation along demonologic lines of comprehension. This aspect may be suggested as interwoven within State-run mental health care facilities via the presence of religious/predominantly Catholic symbolism most notably in the naming of wards within such hospitals or the facilities themselves. Further to the commentary on *'Suicide'* above, in a more direct manner study participants outlined how Church teaching and practice, or indeed the collective memory of now ceased practices, have established shame as a prominent component of the collective community psyche. Individually powerful, one may argue that collectively these direct and indirect aspects of Church dominance have increased potency and have served to negatively direct wider public opinion in relation to depression and indeed wider mental ill health.

The Role of the Media

Thornicroft (2006) has suggested that media content plays an integral role in the proliferation of stigma towards mental illness. Concurring with this view, media coverage of depression was reported by interview participants as being of significant importance in moulding the perceptions that persist in rural Ireland in relation to the condition. The role of the media is discussed below in four sections: *'Media Coverage of Depression'*, *'Benefits of Media Coverage'*, *'Negative Outcomes of Media Coverage'*, and *'The Role of Celebrity'*.

Media Coverage of Depression

Throughout the data participants consistently reported their view that the level of media attention directed towards depression has grown significantly in recent times. Including international, national, local and social, print, radio, film and television, the full spectrum of media sources are noted to have permeated rural society to varying degrees. It is generally viewed that the profile of depression has risen significantly in rural Ireland and across the country, and while remaining somewhat outside of the centre spotlight gaining somewhat patchy coverage, considering the extreme low base to which it had become

resigned, in many respects some surprise was registered as to how quickly the issue had come to generate such a level of discussion:

> 'At the moment it's got a huge media campaign. I think there is huge awareness and it's interesting to see images, a lot of people are unsolicitedly saying "yeah well I suffer from depression" which is (gasps in amazement)! I'm not sure I would say that in an interview and I commend people who do. And I'm talking about people in their 50s, 60s and 70s for who 20 and 30 years ago depression was a taboo thing' (Female, 43, Interview 7).

> 'I can't over emphasise how important it was for Pat Kenny to do one hour (about depression) on prime-time live TV! I mean you get segments every now and again on various programs... but they were segments in shows and they couldn't go into the details too much... but the hour-long one was very important' (Male, 61, Interview 4).

While agreement overall that the media profile had risen was notable, a number of caveats to this potentially progressive development were considered by contributors. Depression as a stand-alone topic was frequently deemed insufficient in merit or profile to garner media attention and, perhaps as a consequence, was invariably discussed alongside or in conjunction with the deemed more pressing issue of suicide or, emphasising the medical model, as within the context of general mental illness:

> 'There is more and more awareness of it (depression) now because it gets a lot of airing on the television and radio. And there is a lot of discussion around suicide in young men unfortunately and unfortunately it has brought that up to the fore to make people aware and to grab the reader's attention' (Male, 61, Interview 4).

Further, there remains a sense that often while there is growing media coverage of depression, it is still not reaching what is seen by participants as the most important and vulnerable audiences:

> 'A really good billboard I saw coming from Dublin yesterday, really, really good; she survived suicide but is still living with the stigma - that's worse it's nearly a life sentence nearly... I remember looking at this really quickly and thought that that is really, really good because that's what it's like... but just say in a rural area we wouldn't see those billboard signs, so how would you reach those rural areas as well, we are really out of the way here' (Female, 33, Interview 13).

> 'All the advertising and all they do about depression at the moment you know, I still don't think it gets to the people who really need it. I saw there in Scotland they did a lot to do with suicide and I heard they were going to football matches and rugby matches to get to the males who are suffering from depression and suicide, I mean it's one of the top killers in Ireland now' (Female, 36, Interview 3).

While coverage is acknowledged to have increased from the low base it once held, some participants felt that a comfortable point has been reached in the public discourse with some of the most difficult issues remaining unreported:

> 'My husband is a fireman and unfortunately a lot of the call outs he goes to now in rural east (name of county) are car crashes and he has often said that "there is no way that there wasn't an intention to go out and kill themselves"... "people knew he was depressed", and nobody is picking up on it. It's also not being highlighted in the media so it is put down as accidental death, it's not put down as suicide you know. So if the media aren't picking up on it ... how are people going to get to know about it?' (Female, 42, Interview 8).

Benefits of Media Coverage

The virtues of increased media coverage were heralded by a significant number of study participants with its role as an educator and in raising awareness of important issues directly or indirectly related to depression receiving particular praise. For many, increased media coverage of depression, even in its most embryonic form, presents the opportunity for a previously unseen and unheard condition to be discussed in a regular manner, a privilege which had been denied to those in previous generations whose media outlets were fewer in number, local in orientation, and invariably bound to the stricter social conventions in the determination of publishable content:

> 'We've got TV shows and stuff... we basically grew up with a word called "depression" you know, and even if that was completely wrong, at least we have something to go on' (Male, 25, Interview 2).

This subtle hint towards the increasing role the media plays in the socialisation process is echoed by others with some suggesting that greater tolerance and a growing mindfulness of depression among the younger generation in particular whose exposure to media sources is significantly greater than in previous generations:

> 'People would be a bit more tolerant because there is a bit more knowledge out there now... on (television channel) for example, there is a lot of ads and stuff like "if your heads away just say" and things like that, and I think that's opening out to people... my niece was talking about a girl in school who just wasn't herself... they just knew she wasn't happy, and they weren't afraid to say it you know, "Jayney, what's wrong with ya?"' (Male, 44, Interview 1).

The power of the media and the potential it holds to reach into the lives of individuals and, crucially in this instance, alter the social and cultural agenda is acknowledged by participants who describe themselves and their neighbours as revelling in an age of information which contrasts dramatically to the recent past:

> 'We have made huge inroads... we can all watch *'Operation Transformation'* and all these programs and we are all eating the right things and we are all doing the exercise, we are being told and it's fantastic!' (Female, 60, Interview 11).

> 'Ad campaigns are trying to address that point, they do something similar with epilepsy at the moment with this person saying "I am this, this, this and this, and I am also an epileptic", as in "it's just another aspect of me and it's not something that should be like woah, woah, woah!"' (Male, 61, Interview 9).

The potential is seen as endless as time and space become obstacles of the past meaning rural residents no longer trail their urban counterparts in their ability to acquire important health-focused information. Instead, such individuals become willing consumers and active shapers of information, open to the reception of education and information from a multitude of media avenues.

Exposure to the constantly evolving world of social media, particularly by younger persons, was also mentioned by a number of participants as a positive development in addressing the perceived stigma towards depression. While in keeping with the above discussion on '"*Keeping The Good Side Out*"' in which questions were posed as to whether such forums have been appropriated for the continuation of a culture of non-disclosure and maintenance of a social façade, again, as has been the theme throughout the discussion pertaining to the importance of the media, social media were typically lauded for the role they serve in the provision of information which may have been previously unavailable.

Such media is also commended for the platform they represent for the open discussion of heretofore socially sensitive issues:

> 'What people do on Facebook, Jesus Christ some of them tell you when they're going to the toilet on it, it's ridiculous! So you know so much about somebody, and they let you into so much of their stuff, but the stuff that's really important, they don't say anything about that...' (Male, 44, Interview 1).

> 'We tend to be a bit more exposed to television and social media and I think we do tend to discuss things more and I think all kinds of things that had always been a kind of taboo' (Female, 27, Interview 16).

As suggested above, however, the age profile of users of such media is a significant factor with participants suggesting that while such exciting and innovative vehicles for potential social progression exist, their penetration in rural society or, in particular, into the aspects of rural society from which the norms and attitudes of rural communities are perceived to be generated, is understood as minimal. Instead, this position is suggested as steadfastly occupied by traditional, somewhat insular avenues of news and information attainment:

> 'A lot of rural folks and older folks, like I mean now you have Twitter, the wonder web... (but) most of these people listen to the local radio and listen to (name of county) community radio which is great and I'm not dismissing it, but there is a world outside your own community radio you know, there is a lot of local (emphasis)... And I think within communities there are a lot of hidden things within rural communities' (Female, 43, Interview 7).

Somewhat surprisingly, little if any mention was made of the capacity for greater interaction and social inclusivity facilitated by the increased diffusion of social media though one may argue that this may be reflective of the age profile of the sample.

Negative Consequences of Media Coverage

> 'It is in the literature, and it's in the programmes on television, and '*The Mad Hatters Tea Party*', you know it's in books for children, it's completely everywhere' (Female, 60, Interview 11).

> 'It (coverage of depression) can be as divisive as it can be helpful and I think they have a duty of care around how they report things' (Female, 37, Interview 23).

While increased coverage of depression within the media was viewed by most as signalling a new era in how the condition will be viewed, a significant number of participants also sought to acknowledge the threat media coverage, or particular forms of media coverage, posed to the formation or further development of perceptions of depression in rural society. While the unfavourable and/or vague depiction of depression in film was mentioned on a number of occasions as being a cause of concern given the wide potential audience and the power of influence upon culture that film media holds, participants held a particular concern for the tendency of the tabloid media to misrepresent depression or unduly associate it with stories centred upon threat or danger:

> 'With the very popular kind of press, it gets very superficial type of treatment... the problem is when you have suicides, high-profile suicides and all of that, the way that they are reported certainly in the tabloid press again, they are not really reported in any sort of analytic way, they are inevitably more sensationalist you know so it's "a cocktail of drink and drugs" and that kind of thing...' (Male, 61, Interview 9).

> 'The media have a lot to answer for... whether it is the newspapers or films or anything like that, depression and mental illness is always portrayed very badly and is usually the villain or the murderous character within a scenario. In the newspapers then it's always about "the madman released on bail", you know with the language that they are using they are deepening the stigma' (Female, 30, Interview 26).

Further to the commentary on the *'The Role of Murder-Suicide'*, a number of those discussing the role of the media made mention of the coverage received by such cases and the potentially negative consequences of this as discussed in the aforementioned commentary.

The Role of Celebrity

A number of participants spoke of the role of celebrity culture in relation to highlighting depression and in the formation of views and opinions about the condition. The majority of participants discussing this aspect pointed to the positive aspects of the association of those who have attained varying degrees of celebrity status with depression as, similarly to the overall impact of rising media coverage discussed above, regardless of the accuracy with which it is portrayed, the mention of depression to a vast audience through the vehicle of celebrity is itself viewed as progressive. Most often, in common with the mention of

celebrity within the commentaries on *'Suicide'* and *'Sexuality'* above, media commentary relating to celebrities and their experiences of depression was viewed in parable-like fashion as participants viewed others as likely to take the meaning of personal narratives and apply them to their own set of circumstances with awareness raised via this consideration of the issue:

> 'Great help I've had from reading books by other people that went through it. (Radio DJ) Gareth O'Callaghan wrote a great book and a few other high-profile people, and it's only when somebody comes out and says "well I went through it and this is exactly what this entails"... I remember hearing that the response that he got to his book was phenomenal... if people who have gone through it don't say what it is and what it isn't, then how was someone else going to know' (Female, 37, Interview 25).

> 'There was always a stigma attached to it but the one good thing you could say that will come out of (the death by suicide of former premiership footballer) Gary Speed and the likes of those recently, was people have become, you know, people can actually talk about it. You know you have the likes of (former premiership footballer) Stan Collymore (writing about his depression) on the Internet and younger people are beginning to address it' (Male, 38, Interview 14).

Concern was also expressed, however, that the popularity of celebrity culture and the interest generated in the stories of celebrity may, in some circumstances, lead to a glorification of depression and, as is mentioned above, suicide. Participants concerned in this manner, some perhaps reflecting the dominance of social secrecy in this regard, felt that given the infiltration of such reporting within their rural communities, the potential for the glamorising of such behaviour or conditions may also have an impact upon those vulnerable to influence:

> 'The Kurt Cobain thing, I think that was glorified... you can see with the Amy Winehouse thing, I saw on TV they broadcasted her funeral and, it didn't glorify the death in theory, but you could say it did in practice by, for example, saying what a wonderful person she was etc, etc, and not focusing on... that this could have been something that was self-inflicted or that arose out of really being in a bad place... but the point is that this is the image that was propagated out into the general public' (Male, 61, Interview 9).

> '(The media) have been publicising quite a bit about depression with people like (actors) Mary McEvoy and Brenda Fricker even Gabriel

> Byrne you know, and I just hear people saying "we get sick up listening to them, why would we put ourselves through listening to their stories?!" It's something like not wanting the glorification of depression... as if it is something to publicise to the whole world whereas most people would think that it is something that should be kept to be dealt with by your family' (Female, 61, Interview 10).

Summary of 'The Role of the Media'

Though at times noted as a vessel which may assist in the perpetuation of erroneous stereotypes and inappropriate glorification and demonisation, overall study participants suggested that wider society appeared to attach significant benefit to the role of the media in relation to the social discussion of depression. Noting its potentially socially transformative qualities, modern media is seen as a vehicle for the dilution of rigid social conventions through the transportation of outside influences directly to rural communities. In relation to depression, which is seen as having gained a significant media profile in recent times as media infiltration expands the appetite for the challenging of social taboos, it is suggested the media has shone a light where heretofore there has been darkness and has thus laid a foundation for a wider discourse upon which an improved understanding may grow.

Generational Differences

Position upon the age spectrum emerges as a key factor in the articulated perceptions of others opinions in relation to depression. Overall perceived views of older and younger cohorts of this rural sample were in line with expected outcomes with participants associating traits of conservatism and liberalism with each group respectively. Older persons within rural communities were seen as investing heavily still in the prominent social conventions of their youth which were often led by philosophies espoused by the prevailing pillars of rural Irish society at that time. The younger generation, while negotiating a social landscape dotted with the remnants of the beliefs of their ancestors, are viewed as less bound by those conventions and open to, and in greater receipt of influence from a wide variety of previously unavailable or censored sources.

Interestingly, within the interview data little if any attention is paid to those encompassing middle age with instead the views expressed concerning those at each end of the age spectrum.

The Views of the Older Generation

Broadly, interview participants described older persons as being the least tolerant or sympathetic cohort within rural communities in relation to those experiencing depression. Many suggested that those in this cohort held ardent and entrenched views which displayed a lack of empathy, grounded, one may argue, in a perceived level of ignorance as to the genesis, impact, and implications of sensitive personal and social issues:

> 'I don't know if it is again a generational thing, and maybe I'm just thinking of the older generation, but I think that maybe before it was that attitude of "keep calm and carry on" like you know, that you have to get on with things' (Female, 27, Interview 16).

> 'We come from a family that is very, very open... (but) my parents' generation? Well it would have been my mom's best friend who would have gone into the (mental) hospital and... her husband took it on his control that, you know, his wife was sick and he has kind of kept her in now and she goes nowhere on her own... maybe the older generation do look at it (differently) and maybe they are not educated about it...' (Female, 41, Interview 18).

Such assertions are supported somewhat by the survey data. A chi square test conducted to test the null hypothesis that there was no significant association between age and personal stigma scores found that the null hypothesis could be accepted (X^2 = 18.550; df = 21; p = .614). However, according to the outcomes of the individual items within the personal stigma scale, the proportion of those within the 45-64 years and 65+ years age categories who expressed a stigmatizing view in response the statements supplied was higher than the proportion of respondents within the younger age categories who expressed same for six of the nine statements. Further, across the outcomes of the individual items within the remaining three scales included within the survey (perceived stigma, perceived social support, and perceived social distance), the proportion of those within the 45-64 years and 65+ years age categories who express views which depict others as intolerant is consistently higher than the proportions of those sharing such views in the younger 18-24 years and 25-44 years categories. Chi square tests to test the null hypotheses that no statistically significant association exists between respondents age and total perceived stigma scores (X^2 = 31.175; df = 31; p = .457), perceived social support scores (X^2 = 9.273; df = 10; p = .506), or perceived social distance scores (X^2 = 26.489; df = 22; p = .231) were also conducted and provided evidence to accept each null hypothesis and thus acknowledge a lack of support for such associations in the target population.

While this depiction of intolerance may seem a rather unflattering judgement to be imposed upon a group, in outlining differing aspects which point to this verdict, participants seldom did so with any detectable form of anger, resentment, or will to articulate a form of chastisement. Instead, there appears a realisation and, expressing an understanding for the social processes which can shape an individual or group, even a sense of allowance that the views held are almost inevitable due to the impact of the configuration of significant influential aspects of their lives throughout their formative years and to this point. A lack of education in this regard together with the popularity of more rudimentary cultural explanations of health and illness feature heavily within responses:

> 'It's generational, which goes back to education, which goes back to life experience and life exposure...' (Female, 43, Interview 7).

> 'That's just the way they were brought up, and some older people would think "well I'm old and that's my excuse"... "Well I'm old and I can do what I want"... it's the culture they were brought up in and it's very hard to change somebody... (It's) an ingrained thing' (Male, 44, Interview 1).

> 'My father is 80, so people of that generation they really have very little understanding of it (depression), it was "laziness" or... "the nerves". But they didn't see it as an actual condition and I suppose they just didn't understand it... I would have grown up thinking that as well you know, because that's what you were living with and that's what you were hearing' (Female, 37, Interview 23).

Interview participants gave account of aspects of the social conditions in which older persons in their communities may have matured which may have exerted an influence upon the attitudes they have sustained over their lifetime, with particular mention of aspects relating to the historical holders of power and the influence they wielded. For example, as discussed above, the role of the Church, not solely in terms of moral teaching but also in terms of its influence upon formal education, and also the medical profession; their influence upon both each other and upon the policies of the State at the time, is notable. Such aspects, in combination with mention of elements of folklore, all operating against the background of a relatively uneducated population is suggested to have created an ideal environment for what may be viewed now as somewhat lazy, naïve, or innocent explanations for challenging social and human phenomenon:

> 'I would probably be described as that you know; "(participant's name), oh the nerves are not right with him!" Because there would be people older than me that would know what has happened to me and will be of my generation a bit older and for them "the nerves" thing is still there, it's not understood' (Male, 61, Interview 4).

> 'A lot of the people around here are older people and they would be saying "oh he's going to be okay, he's going to snap out of it"... definitely of the older generation, I wouldn't say younger people would feel that... It would be "he can snap out of it", "he's just not feeling well"... "Oh he's only looking for attention now", yeah you would hear that definitely and even if you are talking about people in their 40s and 50s that get depressed and if their parents are still alive and they have to listen to that as it's that generation... I don't think there was any education on mental health' (Female, 33, Interview 13).

Further to the commentary on the secrecy associated with depression discussed above, one participant noted how this secrecy is an active aspect of the intolerance said to pervade among this cohort with the unwillingness to discuss depression said to both cause and sustain a closed position on the issue:

> 'Because it (depression) was never discussed back then they are still the same you know, absolutely, 99% of them... my own family would be completely not discussing it, wouldn't mention anything... it's just their way, they're in their sixties, late sixties, a totally different generation, they can't stand how open I am, I do be telling them everything (about her depression)' (Female, 43, Interview 5).

One may suggest that, mindful of the above discussion of the desire for conservatism and reservation in rural communities, such approaches often serve to undermine or down-play the importance or severity of the circumstance.

With an apparent unwillingness to utilise contemporary information in relation to depression, according to the present sample, older generations may be seen to have applied the resources that were at their convenience in order to explain such phenomenon; custom, tradition, and aspects of folklore. That such ideas persist in the face of their revision based upon reason and science which suggests otherwise may be seen as a tribute to the energy expelled by older members of the community in maintaining such ideologically driven understandings as part of their role as the guardians of tradition and custom in rural communities.

The Views of the Younger Generation

> 'Things are changing at a much faster pace than they were and if we are really honest about it, there wasn't that much change between 1900 and 1950, and there was very little change between 1950 and 1980, things are kind of moving at a faster pace now and that's a good thing' (Male, 25, Interview 2).

'It's changing' (Male, 54, Interview 24); perhaps the most frequently cited sentiment in discussion of the younger generation of rural residents. Again in the context of discussing depression and people's views towards it, signifiers of the perceived views of the younger generation towards this subject matter and others emerged.

> 'Well they didn't pick it up off the ground' (Male, 38, Interview 14).

While, as discussed below, overall the picture appears encouraging, it would be erroneous to state that the intolerance which was viewed to be so endemic among the older generation was not also perceived to exist to some extent among the youth of rural communities. A minority of participants noted a degree of overlap in relation to the views of elders being adopted and implemented by young people with this most noticeable with reference to the descriptions reported to be offered in relation to mental health issues by juveniles which resemble the sayings and euphemisms propagated by previous generations:

> 'Even the young people I work with they would be like "oh she is as mad as a bag of cats", you know they have really jovial ways of telling you that there is something going on' (Female, 30, Interview 26).

> 'There is a neighbour of ours now and the kids call her "crazy number one" you know so, the guards have been called there and everything so often so that's there... you can imagine if there is a stark raving lunatic on the street and you are looking to buy the house next door it would be a bit of a deterrent...' (Female, 43, Interview 5).

Supporting this sentiment, within the survey data analysis of total personal stigma, perceived stigma, and perceived social distance scales, of those respondents ≤ 40 and those ≥ 41 years of age, though no statistically significant associations are recorded, those within the younger cohort were found to personally hold more stigmatising views, and also to perceive others to hold such views and desires for social distance compared to those in the older cohort.

Interestingly contradicting these findings however, overall within the interview data participants outlined a perception of progression from the established rationales in relation to depression. Those reaching maturity in modern rural Ireland were broadly described as 'much more enlightened' (Female, 43, Interview 7) due to their greater experience of discussing issues which previous generations of children were, as noted in the discussion of the *'Culture of Secrecy'* above, sheltered from. It is suggested by some that some dissolution of the traditional divide between adults and children within the family may be leading to an expectation towards greater discussion; a considerable step from offered depictions of past family life:

> '(Attitudes) are definitely moving along you know, and I think younger people and older people are starting to chat more nowadays... younger people are so much more open now and are doing more at younger ages, I think older people are kind of feeding off that a little bit and being a little more open and maybe letting their grandkids do stuff that they wouldn't have let their own kids do, being in conversations that they might not have been in with their own kids' (Female, 33, Interview 13).

Encouragingly, as intimated above, younger people in rural areas are also noted as more inclined to reach out to others and were seen as unrestricted in terms of the content they discuss:

> 'For young people, if any of their classmates had mental health problems or anything like that, they would be a bit more understanding' (Female, 61, Interview 10).

> 'It's (stigma) definitely still there but, eh, depression is more widely talked about now... it's not something that's kind of hidden under the carpet. There is a lot of information out there if you want to go and look at it, or need to go look for it, and you can get a better understanding of it, whereas before nobody really talked about it' (Female, 37, Interview 19).

In common with the discussion of *'Suicide'* and *'The Role of the Media'* above, the suggestion is also offered that this progression has been imposed upon the youth of modern rural communities, driven by a tide of outside information directed primarily at the younger, more adaptable generation which has penetrated to rural areas. This influx of information is suggested to have brought, whether welcomed or otherwise, increased discussion of issues of serious consequence into homes across rural Ireland and with that, crucially, a comfort with and indeed an expectation of further such topics of discussion.

A further suggestion for such progression relates to the increased mobility of particularly young community members whose movement outside the confines of the home area has moved from being frowned upon to become expected. The influence of the experiences gained through this departure are viewed as driving the dilution of the dominant mindset of the older generation:

> 'My generation and later kids I went to primary school with, they all got third level which means that they lived somewhere in a bigger group with different people with different ways of doing things, and some of them, but not all, will want to go back and grow old in (name of village) and bring their new (ideas)' (Male, 25, Interview 2).

Summary of 'Generational Differences'

Unsurprisingly, significant variation is perceived to exist between the views of the younger and older generations within rural communities. While older persons are generally perceived as having their views upon depression, mental illness and indeed a wide range of issues informed and moulded into a fixed state by aspects of cultural tradition and custom, the younger population within rural Ireland are seen on the whole as dynamic in attitude and progressive in their thinking and actions in this regard. This outcome is not, however, reflected in the survey data. While tradition is being maintained to some extent, a sense that those of the older generation are becoming accustomed to the faster pace of change that the younger generation is experiencing prevails with, one may argue, increasing longevity and greater intermingling of generations possibly leading to a novel two-way exchange of ideas and understandings and with that a challenge to the established thinking.

Summary and Conclusion

This chapter presented a critical analysis of the key social and cultural factors suggested by the study sample as contributing to the proliferation of the stigmatisation of depression in rural Ireland. *'Social Norms, Values and Expectations'* provided a foundational description of the traditionally imposed distinct rules for living study participants noted to permeate through rural Ireland. These include guidelines in relation to family affairs, individual presentation, gender identity, and sexuality each of which is deemed to be governed by a conservative ideology. This aspect provided an insight into the perceived

restrictive nature of rural society and the defining of normality and deviance. *'Suicide'* detailed the fear perceived to be associated with a family member, friend, or neighbour taking their own life and how this fear, in combination with a deep rooted stigma towards suicide, contributes to the stigma towards depression via the application of courtesy stigma. Also contributing courtesy stigma to a shared pool, *'The Role of the Mental Institutions'* provided an example of perceived historic State complicity with the medical profession in driving the stigmatisation of depression and wider mental illness. This is suggested as emerging through its contribution to and operation of facilities wherein grim histories of draconian practices have served to imprint associations of incarceration and deviance upon the collective psyche. *'The Role of the Catholic Church'* considered the part of the Roman Catholic Church in Ireland in the establishment of social norms through the promotion of a conservative moral ideology, the consideration of supernatural explanations within life and of death, as well as the operation of historical practices towards suicide which, as present evidence suggests, have acted to feed and indeed legitimise the stigma under consideration. *'The Role of the Media'* explored the perceived increasing power and pervasiveness of media and, positively, the potential and realised progression of understanding of depression and wider mental illness seen as being facilitated by the age of information. Lastly, and acting almost as a caveat to the outcomes of the sections which preceded, *'Generational Differences'* provided an insight into the differing viewpoints which are perceived to arise along generational lines and their noted influence upon each other in the production of attitudes towards depression.

As intimated throughout, the above factors should not be viewed singularly but instead as a collective set of features within rural society, at once exerting their own specific power, but also influencing each other towards the creation of a wider culture of understanding.

One may conclude that the contemporary stigmatisation of depression has been profoundly influenced by some of the most historically dominant social forces within Irish society. Traditionally instilled norms and values, themselves both formulated and supported by the historically hegemonic social power brokers of the Church, the State, and the medical profession among others, can be seen to have moved depression along with other mental illness, through practice and dissemination of thinking, within the realm of social deviance and othering. In doing so, this may be seen as promoting the fear, culture of secrecy, and ultimate stigmatisation of depression discussed within the previous

chapter. While the recent broader trend of power shift towards the media may be seen as holding potential benefits for the discourse and for an enlightened future in this regard, the above presented evidence suggests the weight of tradition upon contemporary culture must be considered in the formulation of progressive measures.

The next chapter describes the potential impact of the outlined stigmatisation of depression upon aspects of social support within rural communities, itself a key factor in the perpetuation or otherwise of such stigma.

Chapter Seven - The Social Support of Depression

Introduction

This chapter will outline and explore the views of study participants in relation to the potential availability and provision of social support to those experiencing depression across rural Ireland.

As an important consideration prior to the following analysis, due to the emphasis upon social contact as a key aspect within the concept of social support as detailed in the *'Theoretical Concepts'* chapter above, comprehension of the analysis of the concept in this context hereafter is incomplete without a detailed consideration of the examination presented above in relation to aspects of the stigmatisation of and, within that, desires for social distance from depression suggested to prevail by the present sample. Briefly, to this point evidence suggests that while the personal attitudes of the sample appear mostly accommodative of those experiencing depression, it is broadly perceived that these views would not be shared across rural society. Intolerance, social distancing, distrust, fear, and avoidance among other less facilitative elements were all mentioned within consideration of the likely responses of others towards an individual with depression with a suggestion that numerous ingrained cultural elements were conspiring to produce such outcomes. While this consideration is presented in further detail in the *'Discussion of Findings'* chapter that follows, cognisance of the outcomes presented within the preceding chapters is beneficial at this point.

The views of the sample in relation to *'The Social Support of Depression'* are discussed below within the following themes; *'Home Comforts?'* and *'The Role of the Community'*, with the latter theme containing sub-sections entitled *'Competing Narratives of Social Support'*, *'Social Support towards Depression'*, *'Lacking Social Support towards Depression'* and *'Perceived Social Support Scale'*.

Home Comforts?

Further to the discussion of family and its importance within *'The Stigmatisation of Depression'* and *'Drivers of Stigmatisation'* chapters above, *'Home Comforts?'* refers to the

significant role reported to be played by the family in the offering of both the core instrumental aspects of social support; informational, emotional and tangible supports, as well as the somewhat taken for granted belonging support gained through one's membership of a family unit. As documented previously, mindful of their often large size based upon the inclusion of extended family members, and of their predominantly local establishment, families were seen as crucially important socially supportive units with members of each collective charged with contributing to the fulfilment of the material and emotional needs of their relatives:

> 'I think that most people you talk to now would be saying "God only for my family now I don't know where I'd be" you know what I mean? So there is a great support there' (Female, 59, Interview 12).

> 'People will go; "well look they have a family, you know what I mean? And the family is there to look after them" even if the family may not be doing that... that is none of our business' (Female, 37, Interview 17).

While broad family networks are said to hold a degree of importance, a divide is noted to exist between the extended and the nuclear family, with the latter viewed as the primary focus within a hierarchy of concern. With reference to this more immediate family unit, participants noted that it was this entity which was viewed as most important for the provision of social support with the intimation that for such significant life difficulties, as in this instance depression, 'most people would think that it is something that... should be kept to be dealt with by your family' (Female, 61, Interview 10).

In discussion of family reactions to the experiencing of depression by a family member, highlighting a view that in such instances 'the family knows best' (Male, 73, Interview 15), members of this smaller family entity were viewed as being the primary caregivers to others within this unit. Such individuals were seen as most likely to be the instigators of movements towards addressing the issue via acting as confidants for an initial disclosure, and/or via initiating more instrumental support such as, for example, consultation with medical professionals on behalf of, or in support of the concerned family member:

> 'They won't necessarily seek help from their friends or your extended family... maybe the GP or a counsellor... they would go to places like that but it might not necessarily be the person who is suffering with

> depression it may be a family member who will go as a starting point and ask what to do and where to start with this' (Female, 37, Interview 17).

Participants articulated knowledge of instances among neighbours in which social support, especially the most direct forms, were known to be communicated between family members. Particularly in relation to younger members, though not exclusively so, others within the immediate family unit were seen as in possession of a particular influence which held the potential to produce tangible outcomes in terms of addressing the situation:

> 'It's a lot more difficult to be 45 plus and depressed in rural Ireland than it is to be young... because at 45 if you're depressed in rural Ireland you're not going to go to get help, you're not going to do it like. Whereas if you are younger you have the support around you and you have enough people with influence over you to get you to get the help that you need...' (Male, 25, Interview 2).

Further to the suggestion of the intermingling of ideas between generations within the *'Generational Differences'* section in the preceding chapter, this effect may be seen as unfolding within the nuclear unit also as some argued that this unit has been strengthened due to recent demographic trends thus furthering the perception of a dominant and cohesive familial support framework:

> 'Families are a lot more supportive now whereas years ago... there was so many children in a family, the parents didn't have time to, they were gone and that was it and they got on with the rest of rearing 15 or 16 children... Families are smaller and I suppose parents have more time now... they would have a great bond there, whereas in the past that wouldn't have been there because parents didn't have the time ... I think families are a lot more supportive now' (Female, 59, Interview 12).

While of course one may view that at the heart of these actions lies the altruistic family values of caring for one's children or siblings in a time of need, one may also detect from the data a perception that this role is also assumed with the associated aim of preventing information relating to such matters permeating outside of the confines of this unit. Further to the commentary in relation to *'The Importance of Family'*, *'Gossip'*, and *'Culture of Secrecy'* discussed above, study participants noted their perception that substantial efforts would be made by others to handle situations involving the depression of a family member within the privacy of the family unit amid a concern to conceal the issue from local public knowledge:

> 'It will be used against the family, maybe in a really like pity way; "oh sure God love them sure they have to put up with that"... It is really the typical Irish way that people kind of talk and gossip you know. I think that all leads the reasons why families don't want to disclose it or talk about it because you would have all of that going on' (Female, 37, Interview 17).

Cognisant of the intrinsic importance attached to the family in relation to the provision of a socially supportive environment, one must recognise that even within what is viewed as this most supportive social unit, deficits in social support may persist. A small number of participants outlined such instances in which, again in common with the themes in this section, the stigmatisation of depression can be seen to manifest in the ultimate renouncement of what others may view as one of the core responsibilities attached to the family:

> 'My mum's sister, when mum was in hospital she wouldn't go to visit her, she didn't ring or anything, but when she came out of hospital and she was back to her usual self, then she was calling... she didn't want to be seen in the acute unit or the psychiatric ward or anything... some people just don't want to be associated with it... they don't want people to think that maybe they are sick, or they just don't want to be associated with it, or maybe they're just embarrassed. Which is quite sad really' (Female, 32, Interview 6).

> 'My babysitter, her best friend committed suicide about 18 months ago... she was suffering from depression and she had told people that she was suffering and unfortunately her family unit weren't as supportive of her as they could have been... and the girl just committed suicide' (Female, 41, Interview 18).

Summary of 'Home Comforts?'

Further to the commentary discussing the family in relation to the stigmatisation of depression and the factors driving this, such ties are roundly perceived by study participants as a vitally important element within the lives of those in rural communities with their supportive qualities seen as a central characteristic to their protective role. With this expectation of family support engrained within the common mindset, those external to such units were described to view their place as very much distanced, with a commonly perceived willingness to allow families to privately perform this supportive function in the instance of the existence of depression within that defined unit. Some evidence suggests that this supportiveness may hold the dual purpose of assisting the family member and

also, in doing so, insulating the family from the potential imposition of deviant labelling; a smear upon the family name and their local biography.

Social Support in the Community

'Social Support in the Community' examines how study participants articulated their perceptions of the role those within the community play in the provision of social support in relation to those experiencing depression. Providing some broader social context, this section commences with commentary in relation to the sample's varying conceptions of social support in the community, then turning to give equal account of the diverging opinions offered in relation to others propensity to support those experiencing depression. A critical assessment of relevant survey data is also presented.

Competing Narratives of Social Support

Consensus in relation to the availability or otherwise of socially supportive elements across rural communities was not detectable upon analysis of the contributions offered.

The discussion of social support in this setting was frequently prefaced by participants acknowledging the changes witnessed in contemporary rural society with a number of participants suggesting that emerging rural social characteristics may be contributing to changing dynamics in terms of social support in rural communities. Those who spoke in this manner recognised the transformations which had occurred in rural society which were frequently driven by wider Irish social and economic change with rural communities being mostly viewed as passively subject to, and not drivers of such change. Noted within the *'Drivers of Stigmatisation'* chapter above, the rural lifestyle is seen as having been remoulded by such modernisation, a process which, they argue, has led to increased levels of isolation and the normalisation of the expectancy of same, together with the compromising of the long-established social support framework due primarily to the removal or reorganisation of traditional facilitators of human contact in such areas:

> 'There would be a lot of people who would be very disadvantaged and would not have those core supports... They could be living in areas maybe five or six miles away from the parish church, they are the people who really need or are in trouble, and the only person they see during the day might be the postman or somebody on the television and that's

> their way of life and they have been left to themselves' (Male, 40, Interview 22).
>
> 'They had in the past worked on farms and it was the méitheal system where families would help each other out a lot and they were able to converse a lot while they were working' (Male, 54, Interview 24).

The stories and experiences of study participants in relation to the broad notions of social support appear to span the spectrum of community relations with narratives detailing the active existence of what one may understand as the traditional, perhaps romanticized, almost communal ideal of the socially supportive small community, emerging alongside the views suggesting such idealisation as indeed the work of fiction baring little resemblance to lived reality. In common with the varied outcomes emerging from the quantitative data in this regard discussed below, experiences were recounted which verified the existence of a range of elements denoted within the concept of social support together, and in equal measure with other sentiments which appear to dismiss entirely the likelihood of their occurrence:

> 'There was a lady down the road from us, she had a handicapped son and she was old and widowed, and everyone was doing their bit for her, everyone is helping out, and she was a pain in the ass to deal with but it was grand like and everyone did it... everybody around home put in effort' (Male, 25, Interview 2).
>
> 'Society is not generally like that anyway you know, to call into the neighbour if you haven't seen them in a while, I wouldn't do it. If you haven't seen somebody that is normally out and about I'm not going to knock on their door and see if everything is alright, they will think that I am being a nosy neighbour. I wouldn't do it and I don't think a lot of other people would' (Female, 37, Interview 19).

Notwithstanding this variation in opinion as to the existence or application of socially supportive aspects within communities, interview participants were consistent in their endorsement of the ideal of social supportiveness and broadly expressed a cognisance of the potential benefits it held:

> 'I think and have thought for a long time that that (social supportiveness) is very positive once it gets people talking. I mean I didn't think that I would be able to have a conversation about it (death of mother) to someone in the aisles in Tesco but I can and its great and I just think "my God if I could have had this at the time", to hear other people say "I

know"!" and that "you'll get through it" you know. And personally it has been a huge comfort' (Female, 37, Interview 25).

'Like I went through stuff myself and there was a huge amount of support and still is a huge amount of support and kind of a "fair play to you" you know, I did get myself back on track' (Female, 43, Interview 5).

Of those who did speak of inhabiting a socially supportive community, reflecting the complexity of human relations, considerable variability was notable in relation to the discussion of the sources of general supportiveness perceived to be available and the implementation of this support across rural communities. While distinct mention of informational, tangible, or emotional support were infrequent, a considerable number of participants appeared to endorse traditional notions of community by emphasising the cohesive qualities of same and with that a movement to acknowledge belonging support:

'This is a very caring community... It is very close-knit... My next-door neighbour... was having a stroke and when he didn't show up in the pub on the Monday night as he usually did... they rang him and... they went up to the house... they broke down the door and found him inside, he's alive now... Normally you see other people wouldn't care... but here they went to him at 12:30 at night on a Monday night because he would normally be back and having his few pints, so that'll show you how caring they are because they were keeping an eye on him. Even my neighbours now, and I'm a young 73 you know, but my neighbours if they don't see me they will come up and say "I haven't seen you around a while", and you would tell them if you are going away and they look after the house, it's a caring community' (Male, 73, Interview 15).

The qualities highlighted in the above extract which may be seen as emphasising aspects of belonging support, through their implementation and, indeed, community-wide knowledge of their implementation, are said to be subtle, latent, almost hidden in nature but perceived as a consistent element of community life. Further, it could be conceived that this belonging support may act as a gateway to the other supportive elements; resources which may be drawn upon in times of need with knowledge of such reserve resources described as almost implicit with community membership:

'The supports are there to a certain extent although you may not see it all the time... a lot of people go the extra yard. Like the local guard up there is great with this guy in particular (who) was put off the road for eight years recently for drink-driving, but they would call up to see if he was okay. Now this guy lives in the smaller estates... He would terrorise

> one or two of the neighbours at three or four o'clock in the morning knocking in to see if they have a drink left and this sort of thing, but the following day then they will come back and see if he is alright... there are those hidden supports' (Male, 38, Interview 14).

Mindful of this context of varying social support in rural communities, social support in relation to depression is now discussed.

Social Support towards Depression

In relation to depression in particular, further to the noted centrality of the family discussed above, some participants sought to place family and community neighbours upon an almost equal footing in terms of their ability to provide support or, for example, as a source of confidence. This view was frequently tempered with an appreciation of the importance of the variability of the forms and strength of relationships which may exist between neighbours which, participants stressed, ultimately determine the forms and level of support made available, or indeed the suggestion of this availability from the outset:

> 'Most people would think that it (depression) is something that you, maybe that should be kept to be dealt with by your family or by your immediate neighbours' (Female, 61, Interview 10).

> 'The general neighbour that you don't normally have a lot of interaction with only to say hello passing on the street, especially if they were told that that person "is in a bad way at the moment" ...they would say "oh I don't want to get caught up in that now"... But say if they were like a next-door-neighbour and they were used to talking over the garden wall or whatever I think then it might be a little bit more open to them and to say "is everything okay? Can I get something for you?"' (Female, 37, Interview 17).

However, and unsurprisingly in light of the commentary on stigmatisation outlined above, more often study participants reverted to the more expected demarcation between family and neighbours with, as is discussed above, direction to assert family privacy particularly around such socially sensitive issues. Within the social support hierarchy, while noting the significant variability outlined from the outset, neighbours overall were viewed as inhabiting a distant secondary standing outside of the cohesive family unit. Mindful of the above commentary on *'Gossip'* in particular, neighbours were understood by most to be perceived as a threat to the breaching of family confidentiality and as potential conduits for

the dissemination of sensitive information; in this instance the experiencing of depression by a family member, thus some distance is maintained limiting the opportunity for support conveyance:

> 'Mainly through the family or a very good friend, not so much neighbours, I think the neighbours would be kept out of it even still because the family would be trying to get that person well... I suppose for me when we lived in the village we kept ourselves to ourselves a bit even within the village' (Female, 59, Interview 12).

As participants acknowledged the apparent enforced monopoly held by the family in relation to the provision of social support, it appeared that in common with the findings relating to support within the community generally, the role of the wider community of looser network ties in this regard may converge upon the provision of support which instils a sense of belonging. This belonging support, itself of crucial importance though said to be limited and dependent upon a number of factors, was typically characterized in the form of offering acceptance; 'just treating people (with depression) the same as everybody else' (Female, 32, Interview 6), not differing one's approach to typical daily interaction and maintaining normal social convention to those who may otherwise, due to the weight of social stigma, be expectant of differing treatment:

> 'People give you (person with depression) the same as what they give everyone, if they pass you on the road they will say hello, they would yeah...' (Male, 25, Interview 2).

> 'I don't think people would cross the street... they probably will ask them "how are you?" and see how they are you know? I don't think people would be fearful or want someone to stay away, I really don't think so, but maybe that's the sense of community... I think most people would go out of their way to say you know "how are you and are you well?"' (Female, 27, Interview 16).

> 'I wouldn't say (a person with depression would be ostracized), definitely not if somebody is, you know, they are unwell at the end of the day so no I don't think, I haven't experienced it in this town anyway' (Female, 43, Interview 5).

Two particular caveats to the potential for belonging-focused socially supportive responses within the community were mentioned. Firstly, a number of participants felt that one's personal or familial status and positioning within the community was a determining factor

in whether support in the event of the experience of depression would be forthcoming. Involvement within the community was seen as allowing others the opportunity to form an impression of family and personal identity. This is seen to facilitate a familiarity which, it is perceived, may then potentially stand to the benefit of an individual who comes to experience depression as those within this social network are perceived to soften their potentially discriminatory stance upon the recollection of such familiarity and of the identity image they had previously established for that individual:

> 'If you're involved in the local GAA team or maybe you work in the local pub... and people saying "I hear that guys got depression" you probably get along grand like, but if you are more isolated, do you know what I mean, it might be different... it would be a factor' (Male, 25, Interview 2).

> 'I feel the majority of people would, I think, try to be helpful... I know just for example like any of the lads here (community sports facility) like you know if there was somebody here suffering I know everybody here would go and look after them and call them you know. So if I was to go by that, I think most people would pick up the phone and ring...' (Female, 32, Interview 6).

Secondly, and in concert with the commentary on social distancing contained within the chapter discussing the *'Stigmatisation of Depression'* above, the manifestation of depression is deemed as a determining factor towards the availability of social support with participants noting a distinct unease towards association with those exhibiting overt, typically behavioural signs of depression:

> 'I don't think people would distance themselves unless there was an incident, unless that person got aggravated or aggressive, unless something happened I don't think people would really discriminate against people...' (Female, 30, Interview 26).

In a number of cases participants described circumstances in which it appears that others are more likely to maintain a distance from a person experiencing depression until a point of severity is reached where the person is deemed as almost incapacitated at which point a range of supportive actions may be taken. While this supports the abovementioned ideas of dormant social support and the transformation of belonging to tangible support, one may suggest that this course of action (and inaction), complementing the sentiments noted within the *'Stigmatisation of depression'* chapter, may be due to a distrust of those experiencing depression. Moreover, and again in keeping with the notions of pride and

stoicism discussed above, this may also reflect a fear of encroaching upon another's independence and/or privacy unless absolutely necessary:

> 'There is a man in the community I live in and he has to constantly do the farm work and do everything himself and nobody is offering to help. And they can see that his state of mind is starting to go down and then he attempts suicide, then people might be sympathetic to him and say "oh I can do the herding" or "I can go and do the farm work for you" you know. I think it takes something drastic to happen for them to say "actually he has been down for a couple of weeks..."' (Female, 30, Interview 26).

One may further argue that, again supported by sentiments detailed within the preceding chapters, this reluctance may also be indicative of deficient depression literacy culminating in an inability to both identify potential depression in others, while also lacking the knowledge or skills in relation to rudimentary social support interventions and awareness of the potential benefits thereof.

Lacking Social Support towards Depression

Noting the previously stated considerable variation in the data in relation to the presence and types of social support within rural communities both generally and in relation to depression specifically, a significant trend emerges suggesting that social support in relation to depression is perceived as lacking. Echoing the sentiments around the perceived dismissal of depression and of the perceived requirements for social distance among other factors discussed in preceding chapters, a considerable number of study participants expressed little expectation of a supportive community environment for those experiencing the condition:

> 'Oh no! No I can't see it! Not down here anyhow, I can't see it (support) as being offered whatsoever... I wouldn't necessarily look bad on those people I just think again it's just ignorance and lack of information and they may not know how to interact with that person... with depression nobody knows because is not an obvious illness' (Female, 41, Interview 18).

> 'People are coming for the perspective of understanding depression as being low and being stuck to the bed or whatever; it would be more of a feeling like "they need to get up and get at it". So to come in and be "oh God love you, you are having a hard day, can I do anything for you", the tough love might come into it harder... I don't think there would be as

> much understanding about it; "so-and-so is suffering from cancer would you go and make her a cup of tea?" Or, "so-and-so is suffering from depression would you make her a cup of tea?" (spoken rhetorically), I think people would respond differently to it if they know more of what depression is' (Female, 37, Interview 25).

While the very presence of a situation in which such support is perceived as lacking may be itself of concern, one may suggest that the reasoning offered by participants for this perceived supportive deficit which frequently reverts to an acknowledgment of the presence of stigma-laden attitudes across the community, is particularly troublesome. Further to the above commentary on the *'Suspension of Convention'*, such study participants noted that due to the holding of such views, others would be reluctant to engage with an individual experiencing depression as aspects of normal social convention, deemed central within the discussion of latent social support above, appear to be reserved at this point:

> 'They would be treated differently. If somebody was ill or somebody had cancer or whatever you have all the neighbours going round and asking if there was anything they could do... I don't think you have that if somebody has depression, I think people make a very distinct (separation)... I don't know that they would view depression as an illness... It would have to be a very close neighbour now or somebody might say "look I'll go and cut the grass because she's not able at the moment, I will do it"... People find it easier to do those kinds of things than actually discuss the depression with the person, I think that for a lot of people it would be; "Jesus I won't go there!" (Female, 37, Interview 17)

As intimated above, a number of participants suggested that while they viewed that others may discriminate in terms of their social support provision on the basis of the presence of depression, it wasn't necessarily the condition that was the sole determining factor but that mental illness, as a generalised label, was of greater importance in this determination. Some suggested that, frequently in comparison with somatic conditions, illnesses which involved a specifically mental element broadly remained something to avoid contact with and thus refrain from engagement through which support may be garnered:

> 'There is still that taboo about it... "It's mental", it's a mental depression. Whereas if it was physical people care and they will come and do shopping for people and they do all of that, but if it's a mental thing it's more or less down to the person themselves to kind of pick themselves up' (Female, 59, Interview 12).

> 'They would find it difficult; if someone was physically ill they might offer to do something, but a mental illness? It wouldn't attract that same sympathy because it's the mental illness and people don't tend to understand that like, they just don't' (Female, 55, Interview 21).

Aspects mirroring those presented in the above discussion entitled *'Fear'* were also frequently mentioned alongside this aspect with the suggestion of a deep rooted distrust of those with mental illness.

Upon highlighting this perceived shortage of social support pertaining to depression in rural communities, a number of participants began to piece together the potential implications of this scenario noting in particular the importance of communal relations to one's wellbeing and the detrimental impact of what may easily be viewed as a form of ostracism incurred by a circumstance outside of one's control:

> 'I'd say they would probably feel, they might have their support in terms of their GP or whatever, but I suppose most people... what they need is their best friends or their neighbour or maybe the people they would socialise with themselves and what happens if you can't do that?... like "(who is) talking about me?" Or talking about whoever it is that has depression? "Who is going to ask me what?" Or, you would be sitting there (in pub) and feeling that there is 10 pairs of eyes burning into your back' (Female, 37, Interview 17).

Perceived Social Support Scale

The apparent ambiguity in relation to the community's role in the provision of social support appears to be supported by the survey data. Within the survey, respondents were requested to complete a three-item Perceived Social Support Scale (Cronbach's α = .52) which sought to attain the views of the sample in relation to the perceived likelihood of the availability of informational, tangible, and caring support for those experiencing depression in rural communities (Mickelson 2001). Survey respondents were asked to indicate the level of ease or difficulty they perceived others would feel in providing these aspects of support on a five point Likert scale ranging from 'very easy' to 'very difficult'.

Overall, from a potential maximum score of 15 which depicts a perception of a substantial unwillingness among others to provide the aforementioned social support, the average score of survey respondents in this sample is noted as 9.98 (*SD*= 1.93). This score

suggests that while respondents perceived some considerable reluctance among others in the community to provide the assessed aspects of social support to those experiencing depression, a perception of vehement opposition to the suggested supportiveness is absent.

Taking each aspect individually, a considerable majority of respondents (68.4%) indicated their view that others in their community would experience a level of difficulty in providing information or advice to someone experiencing depression with the majority of those who indicated this (56.9%) expressing that while such a scenario would prove difficult, it may not be exceedingly so. Interestingly, just over one-fifth of respondents (22.4%) indicated that they would be uncertain as to whether others would find the outlined task easy or difficult with, perhaps, this outcome reflecting a degree of uncertainty among respondents in relation to whether the question referred to the provision of such information or advice in relation to depression specifically, or in a more general sense.

In relation to the provision of more tangible supports in the form of help or assistance with household errands, the data suggests a very even split with just more than one-third of respondents describing the suggested scenario as both easy and difficult to differing degrees while 29.3% of respondents expressed uncertainty as to what the likely behaviour of others may be in this regard. In each case of ease and difficulty, the majority of respondents refrained from expressing perceptions of extremes of comfort or discomfort for other people with 33.3% stating that others would find it 'easy', while almost equally, 33.9% perceived others to find it 'difficult' to provide such assistance.

Lastly, survey respondents were asked to express the level of ease or difficulty they perceive others may experience in providing love, care, understanding and reassurance to someone experiencing depression. The majority of respondents (46.5%) described how they felt most others in their community would find it difficult to some extent to provide these supportive aspects to someone with depression, with 8% of the sample suggesting that most others would find this provision 'very difficult'. Just less than one-quarter of respondents stated that others would find the proposed provision of such support easy (20.7%) and very easy (3.4%), while a substantial element of the sample (29.3%) stated that they were uncertain as to how others in society may react in this regard.

With reference to the commentary in relation to *'Gender'* and *'Generational Differences'* presented above, and in particular in relation to the frequent mention of the supposed vulnerabilities of young males, an analysis of the influence of gender upon the total perceived social support scale outcomes controlling for the age of respondents (≤ 40 and ≥ 41 years of age) reveals that males within the younger cohort more frequently perceived others as less socially supportive compared to both females within the same younger cohort, and males within the older cohort. The views of younger males were shared by older females. A chi square test was carried out to test the null hypothesis that there is no association between age and the total perceived social support scale (X^2 = 1.966; df = 2; p = .374). Evidence was found to accept the null hypothesis for this relationship within the target population.

Summary of 'Social Support in the Community'

As intimated from the outset, within the broader discussion of community social support which often prefaced more detailed conversation in relation to the support of those with depression, while broad agreement existed upon the merits of socially supportive elements, significant polarisation as to whether communities held or actioned such supportiveness was notable.

In relation to depression specifically, a number of study participants provided evidence to support the contention that various aspects of social support are in operation within rural communities. Cognisant of the frequent demarcation between the perceived role(s) of the family and that of the neighbour, participants viewed the form of social support to be made available by others in the community both generally and in particular to those experiencing depression as predominantly encompassing the belonging aspect of the concept as family was seen as holding primary responsibility for the other supportive elements. Typically this belonging aspect was understood as latent in nature and centring upon a policy of not altering one's interaction based upon circumstances with the suggestion, then, that the maintenance of this foundation of social interaction provided the platform for the potential implementation of other forms of support if and when required. The levels of prior integration by an individual and/or their family into the local community, together with the outwardly presented severity of the manifestation of depression were noted as factors dictating this community-based supportiveness.

Conversely, a trend in which study participants perceive a lack of social support in relation to those experiencing depression is also detectable within the data. Worryingly, it appears that this deficit in support across rural communities may be driven by stigmatising attitudes relating to depression. Taking consideration of the aspects of fear and discrimination discussed in the preceding chapters, the availability of social support is strained by a perceived legitimised general distancing from depression and, indeed, wider mental illness. The aforementioned aspects are not assisted by the broader social trend towards greater rural isolation.

In common with the outcomes of the social distance and stigma scales detailed above, it appears as though as the level of intimacy of the hypothetical situations presented to survey respondents increases, generally so too does the perceived reluctance of others to associate with those experiencing depression in this manner. Further, given that in this instance explicit mention is made of relatively personal, close-natured hypothetical scenarios, one may argue that the outcomes of this scale provide a particularly strong insight into the perceived expected community responses to depression with a movement away from supportiveness the enduring outcome.

Supporting the views expressed by the interview sample, overall the survey data in this regard presents an image of considerable variability with the outcomes of each item punctuated by an apparent strong sense of uncertainty among respondents as to the likely thoughts and actions of those within their communities in relation to such scenarios. While the potential exists that this uncertainty may be due to respondents experiencing a level of confusion in relation to the meaning of the questioning employed within the scale as suggested above, one may also suggest that the uncertainty which emerges is, consistent with other findings within the present study, symptomatic of the ambiguity pertaining to social positioning around an individual experiencing depression which appears to persist in this setting.

Summary and Conclusion

That social support exists within rural Irish communities is a contested issue among the present sample with comprehension of the elements behind this diverging opinion pivotal to the consideration as to whether those experiencing depression would possibly benefit

from community-based support. The variation in this regard, evident within both quantitative and qualitative datasets, is considerable with an almost even split between those study participants who viewed their communities as supportive environments sensitive to the needs of those experiencing ill mental or somatic health, and those who appeared to endorse a more individualised view of rural Irish society in which it is one's prerogative to avoid intrusion into the affairs of others. Mindful of this divergence of opinion, the above analysis aimed to give consideration to both aspects.

Of the participants who acknowledged the likely presence of social support in relation to those experiencing depression, noting the demarcation between each, the roles of the family and of the wider community were perceived as clearly defined. The family, by way of the particular influence those within this unit are understood to exert upon others within same, was generally viewed as the primary source of instrumental social supports. The wider community, then, was deemed to place emphasis upon aspects of belonging support, typically manifesting through the extension of normal social convention to the bearer of a depression-based stigma. With this belonging support in place, it is suggested the potential may then be seen to exist for the implementation of other supportive aspects upon occasion.

One may suggest that the strong role of the family advanced may account for the lack of full endorsement of the instrumental aspects of social support contained within the survey as, perhaps, the provision of such at times intimate support was seen as not the responsibility of others within the community but solely of the family. One may suggest that participants responded based upon their acknowledgement of the requirement for family privacy and in the knowledge that outside interference would be vigorously resisted. However, again in consideration of the views detailed within the *'Stigmatisation of Depression'* chapter, this allocation of such duties to the family may also be viewed as a convenient route to the perceived desired avoidance of unwanted contact.

Recognising that the availability and/or provision of such support is not guaranteed within family or community settings, comment is also made upon the perceived deficit of social support pertaining specifically to depression within both of these settings. Further to lamenting the apparent impasse in this regard, concern is also expressed as to the perceived reasoning for this with the evidence suggesting that the attitudes and practices

associated with the stigmatisation of depression, as detailed in the preceding chapter, lie at the heart of this perceived social ostracism.

In conclusion, based upon a consideration of survey and interview data, one may argue for the existence of a perception that some level of social support is available for those experiencing depression within rural communities, but that this support did not fulfil the more traditional, perhaps romanticized view of a wholly cohesive, interdependent and supportive rural community model. Instead, the family, frequently seen as acting in self-protection, was seen to take a primary instrumental role accounting for the support of those experiencing depression. Within the community, then, those who recognised a supportive environment acknowledged that this support was most often notable in dormant form due partly to a broad recognition of the demarcation between community and family roles and responsibilities, and also as a result of the stigmatisation of depression leading to a form of social distancing. That potential is noted to exist for the transformation of belonging support to more instrumental supports is encouraging.

Chapter Eight - Discussion of the Findings

Introduction

The preceding three chapters have outlined the findings resulting from an exploration of the stigma towards depression in rural Ireland. The investigation of the views of study participants who identified themselves as rural has found that while personally held views of depression appear to reject stigmatising perspectives, conversely, others in society are roundly perceived to hold vastly intolerant opinions in this regard. Questioning aspects such as capacity, reliability, and authenticity, maintaining associations of fear and threat, and perpetuating a climate of secrecy, others in rural Irish society are perceived to distance themselves from the spectre of depression. Ultimately this may be seen as contributing to the inhibition of the potential activation of resources of social support. The findings also suggest that the development and maintenance of such approaches have been, and continue to be facilitated by traditionally dominant social and cultural forces.

The purpose of this chapter is to critically examine the emergent findings in relation to relevant theory and existing research with a view to enhancing the understanding of the outcomes and their contribution to the discourse.

The Lives of Others

Prior to a comparative analysis of study findings with previous work, a note is required in relation to the implementation of the study design which moved to position participants within the role of informer upon the society in which they reside. Somewhat ironically given the emerging findings in relation to the role of gossip in rural communities, providing a platform for participants to indicate their perceptions of the views of others, with the implicit articulation of judgement and prejudice this requires, has been fruitful in the provision of significant and novel data in relation to the perceived impact and facilitators of depression stigmatisation within rural society. Interestingly, as discussed thus far and below, the outcomes of this approach may be suggested to support the indirect nature of the downward social comparison model of gossip (Suls 1977, as cited by Wert & Salovey 2004).

One must also be cognisant of the dynamic created by this approach within both survey and interview aspects. Acknowledging that a bond is said to form between interactants in gossip (Baumeister *et al.* 2004), in work considering the telling of stories as a means of asserting identity and defining of the 'other' in relation to race relations in Ireland, Moriarty (2005) suggests that participating in the narration or reception of stories often serves to establish the 'other' and the 'self', the 'us' and 'them'. The former is achieved through efforts to distinguish the other typically through an appraisal relative to the perceived qualities of the self, while the latter may be seen as achieved through the reaching of an implicit joint understanding between interactants in relation to the characteristics of the other which sets them apart, and/or criteria which draws interactants into a common understanding, or both.

This outcome is mirrored in the present work as participants in both aspects, through their responses and the stories told through this, defined the 'other' as those within their community broadly characterised as uninformed and intolerant, wholly different from their understood 'self'; educated, liberal and critical. Further, one may argue in line with Moriarty that the telling of the stories constituted the creation of an 'us', comprising the participant teller and the author receiving the narrative. Study participants may be seen to broadly seek to identify with the author as an automatic authority upon the subject under discussion with similar tools to those noted by Moriarty (2005) employed within conversation in order to imply or cement a joint comprehension of shared understanding during interview. In this instance, for example, a frequent tendency to rhetorically ask/assert "you know" or "do you know what I mean?" is notable.

Further and in a similar manner, one may also suggest that through their completion of the survey, and their lack of challenge within interview, study participants also acknowledged a second othered category; those experiencing depression. Complicity with the study in this way may be seen as implicitly acknowledging both those experiencing depression as a social out-group, but also in many but not all cases, as distanced from the participant and the author. This outcome in itself may be suggested to hold some importance as it subtly points towards automatic acknowledgment of the disadvantaged position of this cohort.

Cognisance of both of these relationship dynamic outcomes prompted by the study design are important within the consideration of emergent findings.

The Stigmatisation of Depression: The Persistence of Depression Stigma

Cognisant of the work of Link and Phelan (2001) among others, one may propose that within the present study substantial evidence exists to suggest that each of the elements of stigma are perceived to be in operation, both exclusively and in concert, by this sample of rurally resident individuals in relation to depression within their communities. The label of depression may be seen as entrenched and heavily loaded with almost automatic connotations of deviance from understood normal behaviours, having been labelled as such by the social audience (Herman-Kinney 2003), detectable. As mentioned throughout, and discussed in greater detail in the following final chapter where the potential limitations of the present study are considered, this labelling must be seen as the outcome not just of public consideration of depression but also as resulting from their contemplation of the heavy labelling of broader mental illness. In this sense the present study supports the work of Lazowski *et al.* (2012) who contended the public may not make diagnostic decisions when they consider interaction with those with a mental illness.

Supplementing this undertone of deviance, *'Depression as a Form of Weakness'* and *'Depression as Disabling'*, together with the sections under the heading of *'Fear'*, provide substantive examples of the stereotyping of depression perceived to persist with the findings in relation to perceptions of dangerousness which support to an extent the work of Aromaa *et al.* (2011), particularly discrediting. In justifying their views, participants articulated their understanding that others tended to view depression within the guise of both a personal and/or familial defect, and also as a condition holding the potential to influence those affected to the extent that they come to pose a direct and/or indirect physical and/or emotional threat to those in close social and/or physical proximity. With such attitudes viewed as solidly fixed in place, the perceived desires for separation detailed within the section entitled *'Social Distance'* in particular, are unsurprising. Survey respondents articulated their perceptions that others in the community would prefer, and move to enforce, physical and social separation from those experiencing depression, with the degree of separation desired increasing in line with the suggested intensity of contact. This finding was supplemented thoroughly by the views of interview participants who noted the existence of strategies of avoidance in this regard.

Associating depression with weakness and disability, the loss of status by those experiencing the condition was evident as many participants noted their perception, again

in support of some findings of Aromaa *et al.* (2011), of the inability or unwillingness of others to consider depression as a potentially serious mental illness. The evidence in this regard noted within *'The Dismissal of Depression'* is supplemented further by consideration of *'The Culture of Secrecy'* surrounding the formal or regular discussion of depression, and the conditions suggested consequential relegation to the source and subject of gossip. The findings within the section entitled *'Gossip'* provide evidence towards the attachment of importance to the everyday communicative contexts in terms of the manufacture of sociopsychological constructs (Barnes & Duck 1994) and the learning of culture (Baumeister *et al.* 2004). While the perceived formal preference of others appeared to lie in the outright deference from discussion of the topic, informally, covert dialogue on the issue was perceived as widespread. Such was the extent of this subject arising in or being the focal subject of conversation that, recalling the ideas of symbolic interactionism, a distinct and outwardly circuitous vocabulary has developed in order to communicate about the topic in a code-like manner, a development which, one may argue, serves to confuse and indeed degrade the subject further.

Within the discussion of *'The Social Support of Depression'*, further evidence is presented to suggest the perceived persistence of a consistent level of abnormal treatment directed towards those experiencing depression in matters both of everyday social interaction, but also, and unsurprisingly, within suggested instrumentally socially supportive matters. Assisted, one may suggest, by an understood traditional demarcation of family roles in this regard and by the perceived family interest in avoiding embarrassment and degradation through the maintenance of privacy, a suggestion that the presence of depression may prove an obstacle to social support availability is detectable.

Mindful how Link and Phelan (2001) placed an emphasis upon the presence of the above discussed elements of stigma within a power situation, one may argue that the evidence presented here depicts the rural social environment and rural community life as itself a constant power situation – replete with active fault lines and subtle but omnipresent struggles towards the assertion of dominance or rejection of subjugation. As noted by study participants throughout, access to social resources is viewed as contingent upon the ongoing negotiation of position for both individuals and families with their ability to maintain the outward expression of cohesion and the upholding of entrenched social norms and

expectations crucial in such an environment – tasks perceived as hampered by the presence of depression.

Comparison with Previous Research

To the knowledge of the author this study represents the first attempt toward understanding the perceived attitudes towards, and perceived desires for social distance from those experiencing depression in rural Irish society. Further, no directly comparable mixed methods studies in which the subject matter of the stigma towards depression and the perceived availability of social support are considered exist. Consequently, comparison with previous research is limited to a consideration of studies in which the various components contained within the present study are discussed individually.

With reference to the studies considered within the *'Stigma towards Depression'*, *'Perceived Depression Stigma'*, *'Social Distance and Depression'* and *'Perceived Social Distance and Depression'* sections within the *'Literature Review'* chapter, the findings of the present study may be seen to be broadly in line with previous research. Overall, a view emerges that a considerable stigma is perceived to exist towards the condition. In common with many pieces of previous research in relation to depression and indeed wider mental illness, personal responses to questions within survey scales contrasted substantially with those yielded by the same respondents in relation to their perception of how others may treat those experiencing the condition. With only some exceptions within the present study, personal responses portrayed an image of a sample espousing considerable tolerance and compassion towards those experiencing depression, however, responses recording perceptions of other's likely reactions in this vein suggest a distinct lack of faith in wider society's maintenance of a similarly liberal outlook.

Such outcomes may be interpreted in two ways. Firstly, it may be suggested that the low level of personal stigma held by survey respondents and the consistent intimations supporting this across the interview data, point to the existence of a low level of stigma towards depression. This may mean that while there is a perception within the data that others in society hold intolerant viewpoints, that this may be the result of pluralistic ignorance (Katz & Allport 1931); an erroneous perception pointing to a mistrust or misreading of society by sample participants who, perhaps unjustifiably, project a level of

intolerance onto others. Secondly, and conversely, it may also be argued that in spite of efforts to avoid the interference of self-report bias within the study outcomes as noted within the *'Research Methodology'* chapter, the personal stigma outcomes from the survey and interview data, the latter being limited by design, may not accurately reflect the actual stigma level. This may be due to participants feeling obliged to offer socially desirable answers in which values reflecting tolerance emerge. In this instance, the perceived outcomes may provide a more precise outlook due to participant's ability to accurately portray the views they see to be held within their society without fear of receiving personal scrutiny as they, in effect, place the critique upon sustaining social trends.

Also in line with previous research, within the quantitative aspect of the study in relation to the personal and perceived stigma scales and the perceived social distance and social support scales, greater endorsement of stigmatising attitudes were noted to emerge in concurrence with an increase in the suggested intimacy of the hypothetical statements supplied. Some evidence from the interview data also supports this outlook as many participants, frequently speaking as if engaged in gossip with the interviewer, spoke in broadly unflattering terms in relation to the likely views of others pertaining to potential close associations with those experiencing depression, typically outlining how this contrasted to their own more understanding and compassionate outlook.

The following focused sections will compare the outcomes of the present study with those of previous international research.

Depression Stigma Scales

With reference to the outcomes of the Depression Stigma Scales (personal and perceived), Tables 1 and 2 below provide comparisons of the outcomes reached in some of the previous studies discussed within the *'Literature Review'* chapter above and the data yielded from the present study.

Table 1: Attitudes towards Depression - International Comparison

	Germany	Hungary	Ireland	Portugal	Australia*	Japan*	Alberta, Canada	Present Study
Personal Stigma Scale (% agree)								
People with depression could snap out of it if they wanted	20.1	60.4	18.5	42.4	24.7	47.2	17.0	**3.5**
Depression is a sign of personal weakness	25.9	46.0	18.6	33.3	13.4	45.4	9.8	**4.6**
Depression is not a real medical illness	14.7	27.8	16.5	25.8	14.6	40.2	8.5	**2.2**
People with depression are dangerous	28.6	35.3	14.9	35.5	11.9	14.6	21.9	**9.2**
Best to avoid people with depression so you don't become depressed yourself	13.7	20.3	8.2	24.6	6.9	7.2	3.8	**5.7**
People with depression are unpredictable	36.5	46.2	38.0	70.0	42.2	18.6	45.9	**38.5**
If I had depression I would not tell anyone	25.2	22.5	21.1	27.8	17.0	26.8	13.6	**30.5**
I would not employ someone if I knew they had been depressed	24.3	17.1	20.3	9.2	21.6	38.6	22.1	**11.5**
I would not vote for a politician if I knew they had been depressed	41.3	34.1	30.3	20.3	30.1	58.0	39.5	**8.0**

*Depression vignette employed.
Data Sources: Germany, Hungary, Ireland & Portugal (Coppens *et al.* 2013), Australia & Japan (Griffiths *et al.* 2006) and Alberta, Canada (Cook & Wang 2010).

Table 2: Perceived Attitudes towards Depression - International Comparison

	Germany	Hungary	Ireland	Portugal	Australia*	Japan*	Alberta, Canada	Present Study
Perceived Stigma Scale (% agree)								
Most people believe people with depression could snap out of it if they wanted	47.3	64.8	32.1	55.1	58.9	45.4	-	**62.6**
Most people believe depression is a sign of personal weakness	58.9	50.5	30.7	56.8	52.6	58.2	-	**58.0**
Most people believe depression is not a real medical illness	43.1	42.7	32.4	50.9	52.4	45.0	-	**55.8**
Most people believe people with depression are dangerous	50.5	35.5	26.3	37.8	37.8	32.6	-	**32.7**
Most people believe it is best to avoid people with depression so you don't become depressed yourself	46.6	33.8	23.6	50.2	35.6	32.2	-	**46.0**
Most people believe people with depression are unpredictable	55.2	47.0	42.0	67.5	65.6	35.8	-	**61.4**
If they had depression most people would not tell anyone	62.1	41.0	42.9	63.8	63.1	37.8	-	**74.7**
Most people would not employ someone if they knew they had been depressed	60.7	40.0	41.3	52.6	69.1	65.6	-	**55.8**
Most people would not vote for a politician if they knew they had been depressed	66.2	44.0	43.7	49.3	69.0	73.6	-	**47.7**

*Depression vignette employed.
Data Sources: Germany, Hungary, Ireland & Portugal (Coppens *et al.* 2013), and Australia & Japan (Griffiths *et al.* 2006).

Considering Table 1, both when viewed in isolation and when compared with the previously reported data, the present sample appear in most instances to hold an exceptionally low level of personal stigma towards depression with less than 10% of the sample agreeing with the provided stigmatising statements in six of the nine items on the scale. Contrasting the personal outcomes from the largely intolerant Hungarian sample, for eight of the nine scale outcomes the views of the present sample exhibit greater tolerance with, for example, a divergence of opinion of 56.9% between the samples in relation to the suggestion that someone with depression could snap out of it, and 41.4% in relation to whether depression is a sign of weakness. Though the level of divergence is not as stark, the views of the present sample are also more tolerant for eight of the nine scale items when compared to the Australian sample with 21.2% and 8.8% differences between the samples in relation to the same statements respectively. When contrasted with the German, Portuguese, Japanese, and Canadian sample outcomes, the present sample displays less personally stigmatising attitudes for seven of the nine scale items. Of particular note, more than one-fifth more German respondents felt depression was a form of weakness, over one-quarter more Portuguese respondents felt those with depression are dangerous, 38% more Japanese respondents felt that depression was not a real medical condition, while 31.5% more Albertans would not vote for a politician with depression than the present sample. It is interesting that in common with the Australian, Canadian, Portuguese and Irish samples, the highest personal stigma score within the present study relates to a personal feeling that those experiencing depression are unpredictable. This statement receives the second highest percentage of agreement in the German and Hungarian samples. However, this unpredictability appears as not seen to manifest in a threatening form in the present sample as less than one-tenth of respondents personally associated depression with threatening or dangerous behaviours. While a number of factors may be contributing to the low level of personal stigma reported by the present sample, one may suggest that the high education levels and high proportion of females within this sample may hold importance as Coppens *et al.* (2013) note that more years of schooling and being male held relations to less and more personal stigma respectively across their samples.

Outlined in Table 2, a key feature of the present dataset is the degree of contrast between the exceptionally low personal stigma scores and perceived stigma scores with the variances between the two suggestive of a deep mistrust of others in society in relation to their knowledge, tolerance, and accommodation of those with depression. An example of this presents in the manner in which a mere 3.5% of survey

respondents stated their personal view that it was possible for someone to snap out of depression, while 63.6% of the same sample felt that others think contrary to them and endorse this position. When this aspect is compared to the other studies noted, it becomes apparent that the level of difference between personal and perceived opinion is exceptional with a number of instances in which the difference between such views is over forty percentage points.

In relation to perceived stigma comparisons with those from other countries, the outcomes of the present sample are broadly in line with the perceptions of others elsewhere. However, one notable exception exists as three-quarters of the present sample agreed that others would not divulge their experience of depression to others, the highest percentage agreement across the studies noted. This is particularly interesting in light of the abovementioned commentary upon the *'Culture of Secrecy'* as, compared to the other studies, the present sample also recorded the highest level of personal agreement in this regard (30.5%). This outcome may suggest an extraordinary concern among those within this rural Irish sample in relation to divulging their depression to others and an acknowledgement that others would hold a distinct preference that such an aspect of one's identity would remain confidential.

Considering a comparison of the outcomes of the present rural Irish sample and those of the Irish aspect of the four country study by Coppens *et al.* (2013), in relation to the personal stigma scale, while both samples produced relatively low outcomes, those in the present sample again appear to hold lower levels of personal stigma, doing so in a substantial manner for seven of the nine scale items. In relation to the perceived scale however, while both samples followed the established trend of perceiving others as vastly less tolerant than themselves, a higher percentage of the present sample reported their view that others would hold stigmatising attitudes for each of the nine scale items. Again noting education, the personal scale differential may be suggested to be accounted for by the noted highly educated sample within the present study with most respondents holding at least a primary degree, while this may not be the case in the other Irish sample with the average years of schooling noted as 13.9 years. This difference may be attributable to the sampling methods employed in each study. However, the greater perceptions of intolerance among others, especially when considered with the focus upon secrecy mentioned above, may lead one to further assert that depression is perceived to hold a particularly strong stigma in rural communities than elsewhere in the country.

Perceived Social Distance

As stated, to the knowledge of the author no other work in which the social distance desires perceived to be held by others in rural or broader Irish society in relation to depression exists. Comparable international work in this vein is also limited. Table 3 below provides a comparison between the results of the present study and the work of Wolkenstein and Meyer (2008), one of the most comparable works, in which young people in Germany form the sample. The table shows the percentage of those who disagreed to some extent (somewhat or strongly) with the sentiments of the statements provided.

Table 3: Comparison of Perceived Social Distance Data

% Disagreement with Statement	**German (Youth Sample)* %**	**Present Study %**
Most people would not mind moving next door to a person with depression	25.5	25.9
Most people would be willing to start work with a person with depression	57.2	35.1
Most people would be willing to make friends with a person with depression	69.4	36.2
Most people would be willing to rent a room to someone with depression	43.9	56.9
Most people would be willing to recommend a person with depression for a job if they were qualified for it	72.5	57.7
Most people would be willing to accept their child marrying a person with depression	79.6	77.6
Most people would trust someone with depression to care for their child	84.7	76.4

* Some differing wording used but overall sentiments comparable.
Data Source: Wolkenstein and Meyer (2008)

Further to the Depression Stigma Scale data discussed above, and to the outcomes of studies mentioned within the sections referring to social distance within the *'Literature Review'* chapter, the data yielded from the perceived social distance scale and presented in Table 3 holds a distinct trend in which the perceived desires for social distance increase with the increased intimacy of the suggested interaction. In comparison with the work of Wolkenstein and Meyer (2008), the present sample holds similar traits in that the highest percentages of disagreement within the table correspond to the suggestion of marriage into the family of someone with depression

and such an individual assuming a child caring role. Conversely, comparatively low social contact suggestions of living next door to or working with a person with depression were perceived as unlikely to elicit a distanced response. One may argue that overall the present sample perceive a requirement for somewhat less social distance among others in their communities in relation to depression than the German sample. However, discrepancies in this vein are evident within consideration of the statements pertaining to making friends, working with, or recommending an individual with depression for employment in particular with, for example, the percentage of those perceiving opposition amongst others in relation to making friends almost half that of the German sample of young people.

Nationally comparable qualitative work in relation to depression stigma and social distance is absent, a feature of the discourse which prompted the development of the present study's qualitatively focused configuration. Internationally, comparative qualitative work is limited. Mindful of this, one may argue that the findings yielded from interviews conducted in the present study reiterated many of the points raised in limited existent previous work.

Further to the *'Depression as a Form of Weakness'*, *'Depression as Disabling'* and *'Workplace Discrimination'* sections within the *'The Stigmatisation of Depression'* chapter, the consistent emphasis placed by the present sample upon potential discrimination within working environments mirrors the sentiments expressed by McNair *et al.* (2002) based upon their community meeting and focus group research. In contrast with the findings of this study however, and cognisant that the samples are not directly comparable, concerns relating to acceptability within the family were seldom mentioned within the present study as the predominant perception of participants in this regard centred upon depictions of a protective familial network; both in terms of family members with depression, and indeed in relation to their own interests and reputation. Perhaps suggesting some form of progression, as mentioned in *'The Role of the Mental Institutions'* within the *'Drivers of Stigmatisation'* chapter, within-family stigma towards depression was predominantly viewed as a feature of previous generations which has not carried through to present day.

Further to the *'Culture of Secrecy'* section above, substantial similarities exist between the work of Barney *et al.* (2009) and the present study in relation to the concealment of depression. Others in both instances were perceived to hold misgivings in relation to wider understanding and knowledge about the condition with undertones towards its

ultimate dismissal a common feature between both studies. Unsurprisingly, perceptions of "repellence" (Barney *et al.* 2009, p. 4) and desires for social distance from those experiencing depression are also shared between the studies with the sentiments discussed within the category of *'Fear'* above, such as those within the sub-sections dealing with *'Unpredictability'*, *'Bringing You Down With Them'* and *'Fear of Physical Threat'*, mirroring those within the previous study. The present study, then, may be seen as supplementing the understanding generated from this previous work most notably by providing an indication of the potential driving forces behind these aspects of depression stigma.

Rural Depression Stigma

The present study makes a keen contribution to the discourse pertaining to rural depression stigma. The commentary within the *'Literature Review'* chapter in relation to rural stigma towards both depression, and indeed wider mental illness, may be seen as being supported by the findings of the present study. Firstly, as discussed implicitly within the quantitative phase of data collection and explicitly within the qualitative phase, the rural dimension of stigma as perceived by the present sample may be seen as complimenting the ideas put forward by Rost *et al.* (1993), Angermeyer *et al.* (2004), Hoyt *et al.* (1997), and Griffiths *et al.* (2008) among others who suggested that rural areas were perhaps more conducive to stigma proliferation. Many of the reasons offered by the present sample to support this contention concurred with those outlined in previous research. These factors often centred upon the limited and defined geographical space in which villages and small towns are situated, the propensity of generations of families to remain within this space and hold it as their main centre of affairs, and this confined arena of interaction leading to intensified social interactions and to greater personal and familial recognisability and familiarity within such settings, thus contributing to a perception of compromised privacy.

Secondly, one may argue that the present study has supplemented this outcome by expanding upon this aspect of compromised privacy through the documentation of the concern perceived as held for the reputation of the family within this setting and associated with this, the potentially discrediting nature of a family member's experience of depression. Consideration of this aspect of stigma, an extension of courtesy stigma, is limited in previous work.

Also, further to the commentary on *'Biographical Others'* presented above and cognisant of Goffman's (1963) original consideration of same, the present study may be suggested to further the understanding of this element through its noting of the propensity for the existence of a dense network of extended family within, and the limited familial movement outside of, rural communities. This demographic feature in which generations of families tend to remain resident in one community is suggested as facilitating the construction of historical personal and family narratives. Acknowledgement of a perceived extended collective memory by long established community members, and of the mechanisms by which formulated biographies of ancestors come to resonate upon their contemporary descendants, described by most as a distinctive rural trait, is noted as important. That depression or other mental illness feature as salient aspects within such biographies speaks of the position of such conditions historically, while also providing an insight into how such attitudes are sustained presently through the continued dissemination of local histories.

Contribution to Irish Depression Stigma Discourse

Perhaps the greatest contribution the present study may make may be suggested to lie in relation to stimulating the depression stigma discourse in both rural and wider Irish society, in doing so achieving an overarching aim of this research endeavour. To the knowledge of the author, no previous work exists in which the personal and perceived depression stigma scales, perceived social distance scale, and perceived social support scale used within the quantitative aspect, nor the method of questioning in this vein employed within the qualitative aspect, nor indeed the implementation of a qualitatively dominant mixed methods research approach has been applied to the study of depression stigma focused within rural Irish communities.

Indeed, until the very recent incorporation of an Irish aspect within the work of Coppens *et al.* (2013), this study may have claimed a position as first to explore depression stigma using such tools among any Irish sample. While a critique of comparable outcomes of the present study and this work is provided above, one may also contend that in common with a consideration of the work of McKeon and Carrick (1991), though rurally focused, the present study may act to supplement the findings of enduring and recently published work.

As discussed in detail within the *'Literature Review'* chapter, the work of McKeon and Carrick (1991) as previously the only peer reviewed work of direct relevance to the

subject matter under consideration, was thus used as a form of reference point in the construction of the present study. Through the implementation of a qualitatively focused mixed methods design which sought to address some of the limitations of this study, results yielded may question the applicability of those produced in 1991 to present day Ireland and indeed, due to the extent of the variation of outcomes reached, pose questions as to the original validity of the findings reported over two decades ago which have informed national understanding of this issue to date. While it must be noted that there is some degree of complementarity in terms of the overall findings of both studies, more often the present study contradicts the findings of the previous work both directly, in terms of the personal responses from study participants, and indirectly in terms of the overall responses from participants including those which sought to understand the perceptions of others opinions in a number of areas. Specific areas in which the findings of the studies directly complement each other are obviously confined to the expressions upon assessments of personal stigma. Examples of this include an apparent unwillingness of both samples to look to the affected individual as the source of their depression through weakness of character, feeling sorry for themselves, or variants thereof. Such findings are also supported in the Irish aspect of Coppens *et al.* (2013), though not with the decisiveness of the present sample.

However, much divergence is also notable within the personal responses as the sample within the present study, mirroring the sentiments of Barry *et al.* (2000) in relation to anticipated negative social reactions, appear to express a greater reluctance for social contact with those experiencing depression especially in relation to suggestions of marriage into the family and the care of children. While these aspects had received a more cautious approach from the rurally based elements within the previous study, their levels of discomfort towards such suggestions were minimal in comparison to those yielded in the present study of rural dwellers.

The absence of such substantial polarising responses within the work of McKeon and Carrick (1991) may indeed reflect greater tolerance at that time, or, one may argue as suggested above, such outcomes may reflect the pressure to produce socially desirable answers to such questioning, heightened perhaps by the face-to-face interview technique employed within the homes of study participants. This particular aspect may be seen as lying in stark contrast to the responses offered to similar questioning conducted in the distanced and 'faceless' online environment created within the present study with the outcomes produced suggesting, perhaps, a greater level of comfort among study participants to articulate their true feelings within a non-

judgemental and anonymous space. That only a very small number of present interview participants articulated their personal support for such views further supports this contention. The same argument may also be made in respect of the lesser variation between perceived and personal stigma scale responses in the Irish aspect of Coppens *et al.* (2013) as the contact of a telephone interviewer in this case may also have triggered social desirability bias (Holbrook *et al.* 2003).

In light of the findings yielded in the present study, one may argue that it is the absence of the key elements employed here which serves to highlight further the limitations of the previously published works. That the findings obtained from the perceived depression stigma scale, for example, served to contradict almost entirely those findings from the personal stigma scale in both the present study and in the Irish aspect of the work of Coppens *et al.* (2013) in the least suggests that personally contributed opinions should not be taken as the sole basis upon which social attitudes to such sensitive issues should be considered. Further, in light of their illuminating characteristics within the present study, the absence of consideration of perceived social distance, perceived social support, and of a comprehensive qualitative element considering the operationalization and symbolically driven perpetuation of depression stigma among other aspects within the work of McKeon and Carrick (1991) and Coppens *et al.* (2013), also limits their outcomes and claims towards understanding depression stigma.

One may argue, then, that the failure of the previous studies to seek to include these perception-based aspects of lived experience within their study amounts to a failure to bear a full account of public attitudes towards depression, the central aim of their works. The present study's almost solitary standing in exploring such aspects within the Irish depression stigma discourse reveals its impoverishment.

Drivers of Stigmatisation: Social Norms, Values and Expectations

In his consideration of 'objective culture', Simmel (1907/1978) viewed culture primarily as the produce of people. However, due to their apparent need to materialise and solidify their reality, culture begins to grow beyond their intended scope developing a distinct and separate existence and exerting increasing influence upon its creators; the facilitators of its constant regeneration. This growth was deemed to be enabled by a number of intrinsic components including moral codes, religious dogmas, conventional wisdoms, and ideals whose own individual growth and continued intertwining aids the

overall project. Simmel noted that while the potential always exists to redefine culture, the inevitable power differential has meant that historical precedence lies in favour of culture continually imposing upon the individual rather than vice versa (Simmel 1907/1978 cited in Ritzer & Goodman 2004).

According to Adshead and Millar (2003), "the preservation and maintenance of conservative values and attitudes in Ireland can be attributed to the predominance of 'rural culture'" (2003, p. 6) in Irish society. Further to the mention of 'agrarian values' of stoicism while discussing rural mental illness stigma in the *'Literature Review'* chapter, citing Commins (1986), a form of 'rural fundamentalism' is deemed responsible for the nourishment of a conservative value system as well as a predisposition for deference to established authority in this setting (Adshead & Millar 2003). Within the present discussion of the experience of depression in rural communities, findings have emerged which may support the contention that a fundamentalist form of rural culture persists and exerts an influence upon this experience.

Within the discussion of family, gender, and sexuality in particular, evidence of the preponderance of a contemporary cultural ideology steeped in the traditional conservative elements of Irish society is detectable. Consideration of the narratives pertaining to these aspects provides a valuable insight into the restrictive ethos seen to persist in this setting, the maintenance of strict rules viewed as governing social behaviours there, and crucially the perceived likely response to suggested deviance in this environment. These aspects are discussed below in relation to their impact upon depression stigma.

Family

According to an analysis of the Irish aspect of the European Values Survey data by Fahey *et al.* (2006) as cited by Canavan (2012), family maintains considerable significance across Irish society as 93% of those within the dataset asserted its importance within their lives. The present study can be seen to support this finding as a consideration of family relations lay as a central element in the formulation of responses from the study sample. In many respects one may contend that the findings presented, in particular in relation to the centrality of the family and kinship structures within rural life, mirror those of the pioneering work of Arensberg and Kimball (1940). Though criticised for its structural functionalist approach and the suggested

romanticism applied within its reporting among other aspects (Gibbon 1974), in their analysis the authors established the family as the centrepiece around which community life is formed. Using this as a basis, their ethnographic work then provided an insight into the intricate nature of social relations within rural communities.

The present research both complements and contrasts with the ideas of Arensberg and Kimball in relation to the rural Irish family. The present evidence does not support the much critiqued central consideration of the stem-extended family, an idea whose reign is questioned by Seward *et al.* (2005) suggesting its facilitation primarily by ideology and its establishment upon findings from an unrepresentative segment of population. The noted divide between immediate and extended family in the present study instead complements established Irish trends towards family convergence characterised by a greater emphasis upon the strength of the nuclear family (Goode 1963, cited in Seward *et al.* 2005). However, evidence presented within the sections entitled *'Lack of Anonymity'*, *'The Importance of Family'*, *'Social Distance'* and *'Biographical Others'* does point to the enduring importance of extended family networks, not in terms of living arrangements and focus perhaps, but in relation to the ethos which surrounds this conception of family which is suggested to have remained pertinent. Within this perceptions are articulated of a close, often closed, and almost confined nature of rural community characterised by the typical collection of dense networks of immediate and extended family within that same space. This image presented above supports the "inextricably entangled" observation put forward in the work of Arensberg and Kimball (1940, p. 91) with extended family units within rural communities holding particular importance in the formation of familial and individual identities, both personally and in the eyes of others.

With reference, then, to the above commentary on the requirement for *'Keeping the Good Side Out'*, mindful of the potential enduring social and personal repercussions of failure to do so, one may understand the pressure to maintain the optimal portrayal of an extended family network within the community. This preservation of family standing is noted by participants to centre upon compliance with dominant contemporary rural ideologies reflecting high achievement, economic productivity, and *'Reservation & Conservatism'* among other factors, each of which is noted as potentially undermined by the presence of depression.

Masculinity & Sexuality

Within the present study, perhaps due to the overrepresentation of females within the sample, the discussion of gender (generally together with the discussion of suicide also) typically culminated in the discussion of men and masculinity. The forms of masculinity and femininity which pervade within a culture have been suggested to exert a substantial influence upon the health and wellbeing of the population (Courtenay 2000). In common with the recent work of Cleary *et al.* (2012) in relation to pain and distress in rural Ireland, and the earlier important work of Ni Laoire (2001, 2005) in relation to masculinity in the same setting but reflecting global trends, the dominant masculinity perceived to be performed by others in the present study emphasised compliance with a traditional masculine model holding "physical and emotional strength, maintaining and providing for a family, and heterosexuality" (Cleary *et al.* 2012, p. 8) as central. As noted within the section entitled *'Bog Warrior'*, though explicit mention of the importance of male physical strength was lacking, the need for emotional strength among men across the age spectrum was to the fore as some participants questioned their own perceptions and their propensity to reject males who could not conform to this ideal across various roles. Further in common with the findings of Cleary (2005) and Cleary *et al.* (2012), males in this setting were seen by the present sample as constrained upon a path towards the fulfilment of this expectation of emotional resilience culminating in a movement towards the concealment of personal distress due to a fear of compromising entrenched social protocol or degrading their personal and/or familial social status.

Further to this traditional model of masculinity in which heterosexuality forms a key component, as discussed within the category of *'Sexuality'* homosexuality was viewed as sharing a similar level of stigmatisation to depression in rural Ireland. This finding supports the work of Mayock *et al.* (2008) who found that external social factors such as homophobia and prejudice were contributing to psychological distress amongst homosexual, bisexual and transgender people in Ireland, a common feature across the world in differing degrees of intensity (Bagley & D'Augelli 2000, Ahmad & Bhugra 2010, Francis & Msibi 2011, Semugoma *et al.* 2012). Though not an explicit theme within the work of Mayock *et al.* (2008), consistent mention is notable in the present study in relation to an added degree of difficulty in fulfilling a homosexual identity experienced by those residing in, or who matured in, rural Irish communities due to a level of hostility noted to exist there in this regard. Again, such findings are mirrored internationally (Bell & Valentine 1995, Cody & Welch 1997, Hopwood & Connors 2002, Swank *et al.* 2012).

In their consideration of masculinities, Share *et al.* (2007) cite the work of McKeown *et al.* (1999) who suggested that hegemonic masculinity has evolved to define the most powerful forms of being a man through the subordination of "gayness – a form of masculinity which it is constructed as the worst thing a man can be" (McKeown et al. 1999, p. 23 as cited by Share *et al.* 2007, p. 274). This is reflected within the present study with participants articulating perceptions of deviance in relation to homosexuality as such individuals were seen to be viewed by others as living in contradiction of the established social and indeed moral order. Mindful of this persistent emphasis upon social order, further to the Durkheimian analysis of religion (Durkheim 1912/1965), one may argue that the enduring importance of the Catholic Church within rural Ireland, as discussed within *'The Role of the Catholic Church'*, may account for some of this sentiment of intolerance. Traditional Church opposition to homosexuality in general, as exemplified within its stance upon contemporary movements towards equality for homosexual people in Irish society, may be viewed as exerting a considerable influence upon social attitude formation and proliferation in this regard (Browne 2012, McDonald & Brennan 2013).

In summary, the treatment of each of these factors may be seem to emphasise the perceived restrictive nature of rural society, and crucially, responses to deviance therein.

Drivers of Stigmatisation: The Courtesy Stigmas of Suicide and Mental Institutions

In *Stigma: Notes on the Management of Spoiled Identity (1963)*, Goffman describes courtesy stigma as referring to instances in which a relationship is held "that leads the wider society to treat both individuals in some respects as one" (1963, p. 43). As suggested above in the discussion of *'Suicide'* and *'The Role of the Mental Institutions'* within the *'Drivers of Stigmatisation'* chapter, the present evidence suggests the stigmas attached to each of these aspects individually and in combination must be seen as contributing to the overall stigma which persists towards depression.

The Courtesy Stigma of Suicide

Upon consideration of the responses of study participants within the section entitled *'Suicide'* above which placed the fear of coming into contact with suicide as a driver of depression stigma, one may argue that the stigma of an individual taking their life is

embedded within our collective thinking. This view is supported by Tadros and Jolley (2001) who trace the evolution of thought in relation to suicide from the origins of its stigmatisation within the protestations of Aristotle in ancient Greek thought, through to the reformulation of suicide as a form of sin within Judeo-Christian religions. Adding this moral element, they argue, provided the impetus to the eventual criminalisation of suicide across Europe and elsewhere, furthering its descent into the realm of deviance in collective thought. In their review of literature and offering of personal reflections, Sudak, Maxim and Carpenter (2008) conclude that "suicide remains nearly as stigmatised as ever" (2008, p. 136). Supporting this sentiment in the Irish context, acknowledging its ability to foster "intolerance and prejudice against those seen as different, which can lead to social exclusion and isolation" (NOSP 2006, p. 30), tackling the contemporary stigmatisation of suicide is the on-going goal of the National Office for Suicide Prevention.

Implicitly associated with depression, suicide appears as a topic bearing heavily upon the minds of the present sample of rural residents. One may argue that comprehension of the enormity of the issue of suicide within wider Irish society is reflected within the expressed views within *'Suicide'* as participants exhibit an awareness that Ireland lies in the midst of a crisis in this regard, the gravity of which is matched only by the enormity of the social stigma engendered (Kelleher 1996). Further to its mention while discussing the impetus behind this study in the opening chapter, in 1999 it was reported that Ireland had "the fastest growing suicide rate in the world" (Clarity 1999). Viewed longitudinally, the suicide rate has almost doubled from 6.4 per 100,000 in 1980 to 11.4 per 100,000 in 2008 (NOSP 2011). To further compound the gravity of the issue, some ambiguity persists as it is generally understood that inconsistencies exist in the reporting and classification of suicide in Ireland giving rise to a questioning of the accuracy of suicide figures towards underestimation (Swanwick & Clare 1997, Felle 2005, Datta & Frewen 2010b).

Narrowing the focus to rural Ireland, one may suggest that the rural residence of the present sample may have influenced the apparent high level of awareness of suicide as a social issue. As reflected across the country in local media publication headlines which appear to mirror each other in their mostly tentative descriptions of self-inflicted death witnessed in every community (Riegel 2004, Felle 2005, Horan 2007, 2010b, 2010a, Heavey 2010, O'Brien 2010, O'Dea 2010, Tobin 2010), evidence suggests that higher rates of suicide persist in rural parts of Ireland than in urban areas (Cleary *et al.* 2012). Making the best of available data, citing the work of the National Task Force on

Suicide in 1998, Ní Laoire's (2001) review of the data reveals consistently lower levels of suicide in the more urban and suburban areas in the east of the country within Leinster, than in other more rural provinces. On a county basis, citing the work of Kelleher *et al.* (1997), Ní Laoire notes the admittedly tenuous, but yet consistent link which emerges from the finding that across the country, the predominantly rural counties such as Leitrim, Longford and Carlow among others had the highest rates of suicide while the lowest rates were recorded in the most urbanised county of Dublin.

As outlined within the category entitled *'Suicide and the Social Environment'*, adopting a Durkheimian outlook, study participants appeared to move beyond a purely biomedical outlook instead preferring to attempt an interrogation of the social factors and processes which may be influencing the phenomenon. Discussing the shame that remains attached to suicide, as noted within the *'Church Response to Suicide'*, many in the sample pointed to the social consequences of taking one's own life. In doing so participants reiterated aspects of the important work of Kelleher (1996) in this regard which questions the impact of some Church teaching and behaviours in relation to suicide upon the formulation of traditionally held views upon the issue.

Though no participant directly established the link, by virtue of the consistency of the trend for the continual referral to and restatement of the automatic association of suicide within the conversation upon depression, one must contend that the heavy social connotations and consequences witnessed in the aftermath of this loss towards both the individual after their death and their family, must be deemed to exert a force of courtesy stigma upon the common consideration of depression. Discussion of this aspect of courtesy stigma in relation to depression is absent in the discourse to this point but is, one may argue, crucial to the understanding of overall depression stigma both in this setting and perhaps in wider society due to their evidenced close association both within the clinical literature, and centrally to the current context, in the social imagination and social construction of reactions to depression.

The Courtesy Stigma of the Mental Institutions

Echoing a number of elements contained within Goffman's work on asylums (Goffman 1961), the discussion of *'The Role of the Mental Institutions'* within the *'Drivers of Stigmatisation'* chapter yields evidence to support the contention that a significant stigma is noted to exist in relation to mental health care facilities (McCarthy *et al.* 1995, Keogh 2011). Though shrouded in secrecy, in common with many aspects relating to

mental health and illness in Ireland historically, the legacy of mass institutionalisation within asylums across the country has left a profound mark upon the Irish public psyche. Commencing in the early nineteenth century, enormous numbers of individuals deemed 'lunatics' and later classified as 'mentally ill', as well as those who exhibited none of the behavioural criteria which may fit within these ambiguous terms but instead were deemed to exist in a state of vulnerability, poverty, and/or indeed nuisance, were placed in residence within a national network of publicly funded asylums, later to be termed mental hospitals. Following consistent annual growth in demand for access to such facilities over more than a century, with the exception of a slight decline between 1939 and 1948, in 1956 Ireland's rate of psychiatric hospital bed utilisation was the highest in the world (Brennan 2012). Brennan (2012) argues that factors such as the previous lack of community resources, the sustained programme of construction of increasingly expansive, high-capacity asylum buildings, the emergence of legislation enabling easier admission, together with a strong degree of public demand and support for, and some economic reliance on asylums, were instrumental in the creation of a tendency towards institutionalisation with such facilities seen to be "embedded within local communities" (Brennan 2012, p. 311, 2013).

Mindful of the large number of such institutions across the country, and of their resultant commanding stature within the social environment, and also of the evidence detailed in the present study, one must see their symbolic value as of great importance. Briefly mentioned above, in the absence of "an official narrative" (O' Toole 2013) on the matter, in 2011 Irish public service broadcaster RTÉ produced a two-part documentary series entitled *'Behind the Walls'* (Raftery 2011) in which the history of Ireland's mental hospitals was discussed with contributors including academics, current and retired clinicians, and former residents relaying accounts of the lived experiences of those who inhabited these facilities. Supporting the understandings of study participants outlined above, such accounts portrayed these institutions as essentially dumping grounds for those deemed as socially deviant within Irish society at the time including those suffering from a range of physical and mental disabilities. Further to such mention within the *'The Importance of Family'*, and confirming further the sentiments of the *'Culture of Secrecy'*, others who occupied such institutions included those victims of family attempts to "manage their deviant or troublesome members" as families "for a range of economic, social and moral reasons wished to divest themselves of a problematic member regularly took advantage of the vast network of available institutions" (O'Sullivan & O'Donnell 2012, p.267). That such questionable practices came to pass is suggested to be attributable to the cooperation and collaboration of a

cross-section of social power holders as "families, police, magistrates, clergy and doctors... (took) advantage of lax procedures so as to rid their communities of those deemed troubled or troublesome" (Malcolm 2003, p. 332).

In agreement with the sentiments expressed within the commentary on *'Incarceration'* and *'Medical Power'*, residence within such institutions was noted to amount to effective imprisonment with inhabitants denied their liberty for undefined periods, often subjected to forced labour, condemned to exist in subhuman living conditions, and made to endure often unnecessary and dangerous medical treatments (Rafftery 2011). An "inherently stigmatising" experience, life within the district mental hospitals was often "more austere than those found in many prisons of the twenty-first century" as "in addition to a focus on discipline and labour, the religious ethos of the day meant that the need to atone, or simply toe the line, weighed heavily" while removal from society "was total" (2012, p. 257).

Further to the work of Robins (1986) in this regard, substantiating the views expressed by the present sample and discussed within the *'"The Madhouse" – Stigma of the Place'* above, contributors to the RTÉ documentary also pointed to the power these institutions had over the collective psyche due to some of their core physical characteristics. These included their austere, high-walled, and grey aesthetic presentation, in combination with their location removed from local communities, aspects which served to impose an associated sense of gravity and fear upon the buildings. Also, and reiterating the views of the present sample as outlined within the *'Euphemisms'* section, contributors to the documentary emphasised the importance of these places being evident upon a consideration of how a standardised form of circuitous reference to them had burrowed its way into the collective parlance with reference made to abbreviated place names emerging as a form of common slang. These factors were suggested as contributing to placing these institutions "at the edge of people's imagination" with their power seen as a constant and with that the lingering and implicit threat "of somebody being *in Mullingar* or *in Ballinasloe*" (Rafftery 2011).

In concert with the contributors to this important documentary, and as evidenced within the present data, one may argue that the culmination of the above mentioned factors and the apparent wide public knowledge about these aspects of the mental health institutions has had a considerable impact upon the collective psyche and served to establish a profound fear-based stigma towards mental institutions in Ireland. It may be suggested that this fear, elicited upon contemplation of encountering such facilities

in a personal or family capacity, has also contributed to the stigmatisation of depression by way of courtesy stigma as mention of the condition appears to instantly trigger a thought process of association in which the heavily symbolically loaded spectre of mental institutionalisation looms large.

Drivers of Stigmatisation: Role of the Catholic Church

Within functionalist thought, religion and the symbols held therein operate to exert an influence upon behaviours through their outlining of social norms and values. Durkheim saw three elements as required for religion to develop; beliefs; which distinguish what is sacred and what is profane, rituals; that define how one should conduct themselves within the presence of sacredness, and a church; a single moral community. Religion for Durkheim then, consisted of "a unified system of beliefs and practices which unite into one single moral community called a Church, all those who adhere to them" (1912/1965, p. 62 as cited by Ritzer & Goodman 2004). Through the collectiveness of the church and the rituals practiced there, in doing so continually reinforcing group memory, Durkheim argued that beliefs are learned (Ritzer & Goodman 2004).

In their book *'A Sociology of Ireland'*, Tovey and Share note "the importance of religion in the shaping of our contemporary society, its continuing relevance in terms of everyday social life and the still central role of religious institutions" (2000, p. 120). According to Inglis (1987) as cited by Share *et al.* (2007), one of the defining characteristics of Irish society, is the pervasive and active role played by the Catholic Church in the everyday lives of the population. In spite of trends pointing towards the overall decline of the Church in Irish society (Fahey *et al.* 2005, Inglis 2007), further to the views detailed within *'The Role of the Catholic Church'*, this sentiment of enduring Church involvement in social affairs was shared by study participants. Share, Tovey and Corcoran (2007) in their analysis of religion in Ireland, substantiating the views discussed here in relation to the *'Church's Role in Socialisation'*, and indeed in relation to the *'Social Norms, Values and Expectations'* above, outline the extended range of Church dominance across some pivotal aspects of Irish society. Often moved beyond the purely religious element towards forming an aspect of the identity of the population and individuals within it, the role of the Church in socialisation was and remains significant as it is seen as providing the framework through which such vital aspects of personal identity as gender and sexuality as well as one's moral conduct, were and are formulated. Speaking in relation to this aspect of sexual morality, but as may also be

seen as an example signifying the level of power and influence those in the Church held over broader social life, citing Titley (2007), O'Sullivan and O'Donnell (2012) note that the "men of the cloth were the arbiters of sexual decency" (2012, p.266) holding the power to both define and reprimand deviance in this area as they saw fit. Given the position held and the reach of their influence, "this bred intolerance and severity" (2012, p. 266) in the wider population.

Achieving this influence required a holistic approach. Citing Fintan O'Toole's consideration of the immense 'cradle to grave' institutional power of the Church, O'Sullivan and O'Donnell (2012) outline the vast social remit of the Church who had positioned itself as central within the health care, education, and welfare systems of the State. This allowed the influencing of both key public policy within these realms, and, on the ground, the lives of those interacting with these statutory arms which, in effect, was the majority of the population (Wren 2003, Share *et al.* 2007). Appreciation of this level of pervasiveness, as displayed by the present sample, allows comprehension of firstly how Irish societal norms developed under a distinctly Catholic ethos centred upon an essential conservatism as noted by the present sample, but also, as discussed in greater detail below, a reliance upon supernatural forms of explanation for complex and difficult human experiences and behaviours.

Demonologic Thought

Further to the views of religion as the source of bogus explanations for naturally occurring phenomenon (Turner 1991), the centrality of the Catholic Church, or even of religion generally within Irish society may be seen as contributing to the sentiments expressed within the present study in relation to the continued association between the promotion of supernatural beliefs and the stigmatisation of depression. According to Titley (2007) as cited in O'Sullivan and O'Donnell (2012), those within the Church were "strongly imbued with the spirit of Augustianism – an outlook that emphasised the corruption and sinfulness of human nature" (2012, p. 266). Noting the work of Robins (1986) and Hinshaw and Stier (2008) discussed in the *'Literature Review'* chapter, within the category of *'Spirituality'* study participants provide evidence for what may be argued as the continued impact of religious teaching based within a supernatural or demonologic framework. Recalling perceived commonly held notions of Old Testament Christian doctrine in particular, participants asserted that such notions relating to an individual's spiritual corruption as the source of their depression, while declining, maintained a lingering presence.

In his analysis of Irish suicides, Kelleher (1996) suggests Catholic Church thinking has played a significant role in the proliferation of early supernatural and morally based explanations which have resulted in the further consignment of mental illness to the realms of sin and deviance. Noting the importance of the Church in shaping societal understanding of this issue also, an appreciation of historical Church practice within this area, again generally perceived as rooted within demonologic thought and characterised by the implementation of measures designed to inflict shame upon the individual who had committed the sin of suicide, formed a foundation of his commentary. Within the present study, mindful of the establishment of an intimate linkage between suicide and depression, in the discussion of *'Shame'* and *'Church Response to Suicide'* participants outlined how the cultural residue of these distasteful practices combining "harsh moral judgement and extreme castigation" (Hinshaw & Stier 2008, p. 371) remains within contemporary rural Irish society and its influence upon the proliferation of depression stigma via association.

From the data a perception appears that ambiguity in relation to the Church's views upon depression, broader mental illness, and suicide is widespread. Given this confusion, and the traditional all-encompassing power of the Church, one may argue that it is unsurprising that these particularly powerful images of historical Church practices and beliefs claim such a large aspect within the collective imagination. One may also argue that their appropriation within a shared social narrative in relation to depression and suicide was inevitable as society seeks to form an understanding of such inherently difficult and challenging concepts through all available means, looking to socially powerful institutions for guidance in doing so.

Cognisant of this, then, one may contend that this spiritual element, complete with its associated ambiguous and uncertain nature, serves only to heighten the fear and stigma associated with depression and frustrate attempts to form a coherent open public discourse on same. With reference to the sentiments of the sample expressed within the *'Figurative Associations'* section also, one may argue that moving to, in the first instance, seek clarification, but ultimately eliminate references to the supernatural from association with these aspects may prove beneficial in terms of severing the culturally ingrained, erroneous and ultimately stigma promoting linkages.

Drivers of Stigmatisation: The Role of the Media

Within Bandura's (1986) important discussion of the social formation of thought and action, observational learning forms a key component. Focusing upon learned behaviours, Bandura suggests that even the incidental observation of the behaviours of models within one's environment ultimately exerts an influence upon social learning. Such models include a live model consisting of an individual acting out a behaviour, a verbal instructional model and, crucially in this instance, a symbolic model which encompasses the media. Though in later work stressing that "modelling is not merely a process of behavioural mimicry" (Bandura 2001, p. 275) in doing so emphasising the primacy of agentic perspectives within social cognitive theory, expanding upon symbolic interactionist thought somewhat, Bandura acknowledges the influential role of the mass media in relation to determining human action and affect via psychosocial mechanisms centred upon the comprehension of symbolism.

Taking inferences from the work of Beveridge (1996) on the portrayal of madness within the work of Disney, or Domino's (1983) work on the impact of the film *'One Flew Over the Cuckoo's Nest'* upon perceptions of mental illness as but two notable examples, one may begin to contemplate the substantial potential socialising force and the vast reach which characterise contemporary mass media and its potential influence upon the global discourse on mental illness. Perhaps indicative of what Baudrillard saw as the constant desire and demand of the masses for spectacle within a postmodern world of hyperreality (Ritzer & Goodman 2004, p. 608), a substantial volume of literature exists in which the media is seen as instrumental in the proliferation of stigmatising attitudes towards both depression (Jamison 1998, Francis *et al.* 2005, Johansson *et al.* 2009) and wider mental illness (Wahl 1995, Coverdale *et al.* 2002, Hocking 2003, Corrigan *et al.* 2004, Dinos *et al.* 2004, Thornicroft 2006, Pirkis & Francis 2012). As discussed within *'The Role of the Media'* above, however, while study participants displayed a firm understanding of the centrality of the media within modern society, they differed substantially with the views of those in most previous research in relation to the media's role in furthering the stigma towards depression and, by association, wider mental illness. Acknowledging the detrimental impacts of many aspects of the media's coverage, further to the work of Salter and Byrne (2000), Stuart (2006), and Stout *et al.* (2004) among others, Byrne (2000) also recognises the potential stating that "ultimately the media will be the means of any campaign that aims to challenge and replace the stereotypes" (2000, p. 66). Based upon the views of the current sample, one may tentatively suggest that this progression may have begun with many participants choosing to extol the virtues of what they perceive as a recent shift

of the media's focus towards constructively addressing the stigma towards depression and its potential consequences.

Discussion of the media with study participants typically maintained a local, Irish focus. While comment upon film and print media were limited, nationally focused television and radio programming, supported by aspects of social media, were seen as having moved to adopt, or perhaps given the role of some such media as state broadcasters with an obligation to reflect modern Irish society, were compelled by national circumstance to assume the lead role in advancing the public discourse on the matter.

Though some criticism of the media occurred within the present study, particularly, and in line with previous research, elements of the tabloid media in relation to editorial tendencies towards sensationalism and sweeping generalisation (Nairn 1999), the dominant sentiment expressed by the sample focused upon the positive aspect of the elevation of depression from a position of obscurity onto the public platform as facilitated by media coverage. In common with a finding within Nemec's (2005) review of depression awareness campaigns, this consideration of depression by the mass media was seen within the present study as bearing benefits in terms of improving depression awareness and literacy in others, and while the latter aspect was often noted to include the proliferation of erroneous views, this still was recognised as progress of sorts. Also in common with the work of Nemec (2005), appreciation of the value and utility of high profile individuals in achieving these aspects was mirrored by the sentiments of the present sample expressed in relation to *'The Role of Celebrity'*. Incorporating, one may suggest, aspects of Bandura's notion of the live model, the presence of such individuals within the media was seen by the present sample as a conduit for social learning on two fronts; firstly via the contact with and consideration of the content of the personal narratives shared, and secondly by the broad exposure afforded by the profile of the individual.

Drivers of Stigmatisation: Generational Differences

Considering the above discussions of dominant social norms, values and expectations, suicide, mental institutions, and the Catholic Church, one may suggest that retrospect is a common theme as in each case study participants, in their endeavours to accurately articulate their perceptions of contemporary rural society and contemporary depression stigma, gave significant consideration of the past. Invariably, in the instance of each of these topics, this reflection evoked broadly negative responses as

participants recalled from both experience and perception, stifling social norms, the cruel and unusual treatment of suicide, substantial social power differentials, the terror and enduring threat of unjustified incarceration, and the social oppression of Church rule. The past, then, is broadly perceived as a bleak, secretive, black-and-white time detached from the supposed modern transparent and high definition reality. Further to the discussion of *'Generational Differences'*, within the subsection of *'The Views of the Older Generation'*, one may argue that the prevailing attitudes and social conditions of the past have come to be associated with older people within rural communities as intolerance and a closed mentality are noted as dominant themes among this cohort. This aspect is highlighted further upon a comparison with the perceptions of *'The Views of the Younger Generation'* in which optimism and a general liberal and transformative outlook is said to pervade. The findings of the present study broadly subscribe to those within a literature review conducted by Ireland's National Centre for the Protection of Older People (2009) considering perceptions in relation to the views of older people in general, in which pessimism, suspicion and prejudice are described as features of advanced age. Also, the reasons offered within the present study as to why these opinions persist broadly concur with those outlined within the international and domestic literature which includes the maintenance of a conservative ideology driven by increased religiosity, and a perceived tendency to remain 'set in their ways' in terms of thought and behaviours.

In relation to depression stigma, the broad expectation among the interview sample that older persons in their community would harbour more stigmatising attitudes, which were ultimately largely unfounded upon consideration of the present survey data, complies with findings within the work of among others Aromaa *et al.* (2011) and Griffiths (2008) with the latter suggesting targeting this cohort within stigma reduction programs. Older age was also noted as a factor, though not a very strong factor, in a review of predictors of personal depression stigma (Calear *et al.* 2011).

While the views expressed in relation to the attitudes of older people towards depression may be construed as reflecting a level of ageism within the present sample, one may also suggest that such views have been significantly influential in determining the outcomes of the present study in which a perception that others in rural society stigmatise those experiencing depression is widespread. Noting the significant improvements in life expectancy over the course of the last century (Wang *et al.* 2012), research suggests that older persons are assuming and maintaining greater roles within the family and in the care of grandchildren in particular (Share & Kerrins 2009).

Further to the evidence which suggests that intergenerational contact may influence trends in stereotype and attitudinal formation (Aday *et al.* 1996, Pinquart Silka Wenzel 2000), in keeping with the symbolic interactionist focus upon socialisation discussed above, and given what Arensberg and Kimball saw as the relationship of "extreme superordination" and "extreme subordination" (1940, p. 59) between parents and children respectively, one may suggest that the nurturing of views gained in the less enlightened past and maintained by older people may be exerting an influence upon attitude formation presently.

The Social Support of Depression?

To the knowledge of the author, this study represents the first attempt towards discussing perceptions surrounding the provision of social support in relation to those experiencing depression in the community in either a rural Irish or broader Irish societal context.

While it is argued above that one may consider a number of the aspects of contemporary rural life depicted within the present findings as mirroring those put forward in the work of Arensberg and Kimball (1940) which served to define an enduring image of rural Irish communities, consideration of the present discussion in relation to the perceived availability of social support may temper broader comparisons. Within their conception of rural Irish community, emphasis was placed upon the sense of social cohesion said to persist with the méitheal, as an example, highlighted as a symbol of the perceived rural cultural disposition towards instrumental cooperation inspired and maintained by a socially supportive community ethos. However, while notions of latent social capital within the community are detectable, the findings within the present study in relation to social support, crucially when taken in combination with the findings pertaining to stigma and social distance discussed above, appear to question the current status of this ethos and its applicability in the case of those experiencing depression in rural communities.

Mirroring a finding in work by Chambers in which almost two thirds of Irish respondents expressed that "these days people don't really know who they can count on" (Chambers 2007, p. 24) the faith of study participants in the capacity of their neighbours to provide emotional, tangible or informational support to an individual experiencing depression was underwhelming with a perceived difficulty in providing such support a dominant theme throughout the survey data. These findings were

supported to some extent, though not entirely, within the interview data related directly to the topic, however, when viewed within the context of the wider study, this substantiation expands. Mindful of this, the outcomes of the social support aspect and their implications are discussed below.

The high percentage (68.4%) of survey respondents who felt that others within their community would feel a level of difficulty in providing advice or information to someone experiencing depression is concerning. One may suggest that this outcome, in line with present outcomes and previous research in relation to social distance, may be viewed as broadly suggestive of a perceived unwillingness of others to engage with depressed individuals. One may also contend, acknowledging the possibility that this question may have been construed as referring to the provision of information and/or advice in relation to depression only, that this perceived reluctance to pass on information may be indicative of a perception of deficient depression literacy with respondents evaluating the level of knowledge they perceive to be held by their neighbours in relation to depression. In this case, though previous vignette-based work conducted in Ireland at a national level suggests that most adults can correctly identify depression (Chambers 2007), other and rurally focused work has found depression literacy to be quite variable. In research from America by Deen and Bridges (2011) in which the depression literacy of a rural sample was examined, while their review of previous relevant international literature found great variation across and within populations and over time, in their own work only 53% of respondents were able to identify the condition. Though not directly comparable in terms of rurality, their findings appear favourable in comparison to work from Australia a decade earlier (48%) (Wright *et al.* 2005), but less so when compared to findings from work conducted in Canada (76%) (Wang *et al.* 2007). Considering this noted variation in literacy, and in light of the other perception based findings within the present work and the findings of previous work within the Irish context such as that of MacGabhann *et al.* (2010) discussed above, suspicion towards a possible perceived low level of depression literacy in the rural Irish setting may be merited.

The finding that a majority of study participants perceived others would experience difficulty in providing emotional support for an individual experiencing depression is also concerning and similarly may point to a perception of desired disengagement from such individuals among participants neighbours. However, counter to such an assertion, one may argue that this finding, when considered beside the detailed findings in relation to the primacy of the family within rural life, may perhaps be due to

an acknowledgement of and adherence to the traditional boundaries within rural society rather than of an unwillingness to engage in such a manner. Further to the discussion of the importance of the family both in name and functionality within the *'Drivers of Stigmatisation'* chapter, the *'Home Comforts?'* section within *'The Social Support of Depression'* chapter provides further details of the perceived demarcation between public and private family matters and the hierarchy of care perceived as governing such affairs. Similarities are notable with the sentiments of Parsons's depiction of the 'sick role' (Parsons 1975) in that the individual, to an extent, becomes othered due to their condition, exempt from normal social conventions and roles and, in this instance one may argue, becomes a form of ward of the family. Contrary to what Parsons saw as the voluntary nature of this process, one may argue that a range of social processes conspire and activate to force this development, not least, as noted in the data, the apparent categorisation by others of an individual with depression as the sole concern of the family thus meriting and even necessitating their physical and social distancing.

Further to this view, upon consideration of the data concerning perceived depression stigma and, in particular, perceived social distance within the present study, one may contend that discriminatory attitudes perceived to be held by others in the community may be equally if not of greater importance in considering the perceived reluctance of others to engage emotionally. As discussed above, in common with similar work conducted previously, the trend within the present data for greater perceptions of increased desires for social distance among others in line with the greater intensity and intimacy of the hypothetical actions considered may be seen as substantiating the findings in relation to the difficulty perceived to be posed in the provision of emotional support. The perceived unwillingness of others to embrace a person experiencing depression into their family via marriage, and the perceived discomfort with such an individual caring for a child, two strong examples, point to a perception that trust is seen as lacking among others in this regard, thus compromising a foundational element required for the development of relationships (van de Rijt & Buskens 2006).

Finally, in relation to tangible support, the outcome that a low proportion of survey respondents perceived that others would easily provide such assistance to someone with depression appears substantiated in light of consideration of the interview data with strong themes related to perceived desires for physical and social separation evident throughout. With these findings supported by the sentiments emerging from the outcomes of both the perceived stigma scale, and in particular the perceived social distance scale, again, suggestions of welcomed close contact are rejected. Such

findings, while perhaps again reconcilable with the emphasis on demarcated family roles, support Goffman's (1963) assertion of the required avoidance of contact with stigmatised individuals by the non-stigmatised and with that the majority of existent research presented in relation to depression and mental illness related stigma above. While survey respondents were commenting upon their perception that others would lack a willingness to provide such support, on a purely practical level the perceived desires for the separation and segregation of such individuals places the realisation of such supportive resources further beyond reach.

Indeed, upon broad consideration of the outcomes pertaining to perceived stigma and perceived social distance, both quantitative and qualitative, in addition to those outcomes pertaining explicitly to perceived social support, one must conclude that the opportunity for the utilization of social support resources may be significantly curtailed by virtue of the existence of powerful attitudinally based elements. Such factors are seen as acting to place physical and behavioural obstacles before the occurrence of everyday encounters deemed so important for the effective communication to an individual that they are valued and cared for by others (Barnes & Duck 1994).

Summary and Conclusion

The aim of this chapter was to discuss the findings of the present study in relation to relevant theories and existent research in order to situate the views expressed by the study sample within the wider library of thought upon the subjects and issues under consideration.

'Stigmatisation of Depression: The Persistence of Depression Stigma' outlined how a consideration of each data element within the present study may lead one to understand depression as a condition perceived by the study sample as holding connotations of deviance, weakness, and threat in rural communities. These outcomes suggest that depression is seen to contravene established rural social norms; a situation which has led to a perception of both those experiencing the condition, and the condition itself enduring a downgrading of social status. Comparison with previous research reveals the present sample to hold relatively low levels of personal stigma towards depression while broadly mimicking trends from previous research in terms of higher levels of perceived stigma and perceived desires for social distance in others. The intricacies of the latter trend quickly emerge upon consideration of the qualitative data with the capturing of detail pertaining to a dominant culture of secrecy in

particular, crucial to the explanation of particular variations from the established trends within the discourse. Note is also made of the contributions of the present study to the discourses surrounding rural depression stigma and, perhaps most notably, this stigma in an Irish setting.

The subsequent four sections deal with the aspects discussed within the *'Drivers of Stigmatisation'* chapter. Social theory and commentary is put forward which may contribute to an explanation of the restrictive form of rural culture said to persist. Classic and contemporary research is then presented which provides support for the findings emanating from the present sample in relation to the perceived enduring centrality of the family, and the dominance of one and degradation of other forms of both masculinity and sexuality. Such aspects are suggested to provide evidence as to the perceived restrictive and indeed static nature of social thinking in rural society; the context within which the depression stigma under consideration is situated.

Supported by existing literature and documentary evidence, the case highlighted, mainly implicitly, by study participants towards the inclusion of the courtesy stigmas of mental institutions and suicide in any formulation of persisting depression stigma is put forward, while associated with these aspects, discussion surrounding the stigma promoting historical practices and demonologic teaching of the Catholic Church are also interrogated. Counter to established thinking, a tentative suggestion is made that the media may be beginning to use its substantial power towards the alleviation of depression stigma, while finally, the foundations of perceptions of the supposedly broadly intolerant views of older persons in society towards depression are questioned.

Lastly, in light of the present findings, the suitability of the traditional cohesive understanding of rural society is questioned while concern is also expressed as to the likely provision of social support to those experiencing depression in rural Ireland based upon substantial evidence to suggest avoidance of contact with such individuals, and the stated importance of the sanctity of personal and familial privacy. In its place, a suggestion of latent and potentially transformative social support is put forward.

In conclusion, while, unsurprisingly, reported personal opinions towards depression appear progressive, key findings of the study suggest that a perception persists that others in the community maintain a considerable level of stigmatisation in relation to those experiencing the condition manifesting in a perceived desire for distance, both physical and social, from such individuals. When such barriers to interaction are

considered alongside the broad perception that others may hold a degree of reservation towards extending elements of social support to a person with depression, a perceived culture of intolerance and discrimination may be seen to manifest.

The work of Link and Phelan (2001) is central to explaining the stigmatisation of depression described by the present sample as the notable convergence of their outlined key components towards the facilitation of stigma, within the power situation of the rural community in this instance, is abundantly evident within the findings. Further to this, mindful of the concepts outlined within *'The Work of Bourdieu'* above, deeply entrenched aspects of rural culture may be seen as facilitating the continued regeneration of the circumstances in which these components thrive, with institutional power also exerting a considerable influence upon the creation of fertile conditions for resultant discrimination. These aspects may also be seen as hampering the transformative potential of social support through the stifling of the critical examination of the prevailing circumstances and limiting the social contact with those experiencing the condition.

Chapter Nine – Conclusion

Introduction

Adopting a symbolic interactionist theoretical framework and employing a pragmatic, qualitatively focused concurrent embedded mixed methods approach, this dissertation provides evidence to suggest that depression is viewed as a considerable target of stigmatisation in rural Ireland. Further, this work also explores the key cultural factors suggested to contribute to the proliferation of this stigma and the impact of the presence of depression upon potentially socially supportive relations in the community.

This final chapter aims to provide a summary of the key study findings presented and developed in chapters five through eight while the central claims of the analysis will be situated in terms of their contribution to existing theory and literature. Preceding discussion of the outcomes of analysis, in order to set the context in which the conclusions drawn should be considered, the study aims and objectives and methodology will be briefly revisited. The theoretical and research implications of the work will be detailed together with recommendations in relation to education, research, policy, and practice, while lastly, the study limitations will also be outlined.

It is internationally recognised that, especially in rural areas, experiencing depression is associated with experiencing stigmatisation. However, both internationally and in Ireland, empirical research exploring this issue within such settings is sparse. This study aimed to address the lack of research consideration of this major contemporary public health concern through engaging with a sample of residents of rural Ireland with a view to exploring the characteristics of contemporary depression stigma, perceived factors contributing to its establishment and proliferation, and perceived impacts it has upon social relations in their communities.

To achieve this aim, the author endeavoured to meet the following objectives:

- To explore whether persons experiencing depression are perceived to be stigmatised in rural Ireland and how this manifests,
- To enquire as to the key factors facilitating the proliferation of the stigmatisation of depression in this setting,
- To determine if potential access to social support in rural Irish society is perceived to be impacted by one's depression status.

Incorporating a mixed methods research design, quantitative data was collected via an anonymous online survey of individuals who identified themselves as rural while qualitative data was collected via a series of in-depth semi-structured interviews. Recruitment for both aspects was founded upon collaboration with a national representative organisation for rural organisations who distributed study details via email to their affiliates following the snowball method of distribution. In this way recruitment of participants for both aspects employed non-probability purposive sampling. Ethical approval to conduct the study was provided by the Research Ethics Committee of the Health Sciences Faculty within the University of Dublin, Trinity College.

Empirical Findings

The original contribution to knowledge of this work lies predominantly within its exploration of a perceived stigma towards depression in rural Ireland. Within this, this work documents and explores evidence which points to core societal characteristics as facilitators of this stigma in this setting. Furthermore, this study also supplies evidence to suggest that the potential supply and utilisation of key resources of social support are being inhibited by this intolerance which is exerting a negative impact in relation to potential social tie formation and maintenance.

Summaries of key study findings are presented at the end of the three chapters entitled *'The Stigmatisation of Depression'*, *'Drivers of Depression Stigma'*, and *'The Social Support of Depression'* while further brief summarisation, critical and comparative review is also presented within the *'Discussion of Findings'* chapter. This section aims to synthesise these study outcomes towards the provision of answers to the research questions.

Are those experiencing depression perceived to be stigmatised in rural Ireland and, if so, how does this manifest?

Analysis of present evidence suggests a culture of stigmatisation in relation to depression is perceived to exist in rural Ireland. Despite overall low personal stigma scores within the survey aspect and some intimations of similar sentiments within the interview data, in-depth discussions interrogating the perceived views of others within their community in relation to those experiencing depression, supplemented by survey data which also dealt with such perceptions, together with data from both sources

discussing perceptions of desires for increased social distance, leaves no doubt that depression is perceived as stigmatised in this setting. Mindful of Link and Phelan's (2001) dominant contemporary definition of stigma, the evidence presented suggests differentiation of those experiencing depression on the basis of the condition. Within this, evidence points to the instrumental role of cultural beliefs in tying those labelled to negative attributes such as weakness, disability, and threat, the othering of those placed in such a cohort, the loss of status of both those experiencing depression and of depression itself, together with ongoing practices towards and legitimation of discrimination across a number of key social arenas and power situations on the basis of experiencing the condition.

In terms of the manifestation of this stigma, as with other more severe mental illnesses, fear is noted as a dominant emotion engendered within others by depression as the sample detailed their perception that others viewed those experiencing depression as posing both a physical and emotional risk to their wellbeing and to the welfare of vulnerable others.

Such is the level of nearing untouchability depression has come to occupy within the eyes of others according to study contributors, the condition has become entangled and restrained within a culture of secrecy. This culture has, it is argued, moved to deny depression positioning as an acceptable topic of open public discussion, instead consigning it to the realm of underground discussion with this demotion taking the form of covert gossip complete with a distinct lexicon to facilitate locally coherent and, crucially, what is viewed as discreet symbol exchange. One may further argue that encapsulating the condition within this culture acts to effectively enforce the social distance perceived as desired by others as the subject, along with the discomfort it is said to instil, becomes removed from everyday conversation and consideration.

What are the key factors facilitating the proliferation of the stigmatisation of depression in this setting?

Comprehension of the form and intricacies of rural culture said to pervade within their communities is noted by study participants as crucial to understanding contemporary depression stigma proliferation in rural Ireland. This culture is noted to focus upon a Catholic Church influenced conservatism, and a nearing obsession in the maintenance and projection of a defined normality or indeed extended achievement within such normalcy. Participants provided a detailed account of a broadly restrictive social

environment in which difference from the established social and indeed moral order bore considerable undesirable repercussions both for an individual and their family. In combination with this, other historically socially salient issues, namely suicide and mental institutionalisation, are seen as contributing to the ultimate undermining of depression via their input of courtesy stigma following their own degradation at the hands of socially powerful forces including the Church and medical profession, both operating in cooperation and/or collusion with the State.

As the holders and disseminators of custom and tradition, older community members were widely viewed as inclined to maintain a rigid allegiance to the frequently erroneous and stigma inducing thinking propagated by the rural power holders of their youth. While analysis of personal stigma survey data undermined the certainty of such a view, interview participants roundly chose to lay some blame for current depression stigmatisation upon those seen as transporting the ideals progressed by historical practices through to present day, with greater contemporary inter-generational interaction also a mentioned factor.

Contrary to expectation and previous research, the role of the media was outlined by the study sample as having undergone a movement towards the ultimate benefit of the depression stigma discourse. Aided somewhat, and indeed in many cases tragically, by the apparent increasing importance of celebrity, many study participants outlined a view that others in society were being educated about depression through the media. While this development came with potential concerns, the absence of discussion of the condition from other sources heretofore meant that the new level of media attention was broadly welcomed. Though in its infancy, through wide media penetration and its apparent liberal discursive practices pertaining to its coverage of depression, this traditionally taboo subject is seen to be beginning to receive attention and generate noise where traditionally secrecy and censorship prevailed.

Is potential access to social support in rural Irish society perceived to be impacted by one's depression status?

Ideals of the traditional and often romanticised form of supportive rural Irish community, while held in high esteem, are not fully supported upon consideration of the present study data as opposing views in the debate as to the very existence of social support within the community emerge in almost equal measures. Further enquiry reveals the study sample appear to endorse the strong position of belonging support with the

suggestion that this lies predominantly dormant but with transformative potential as more instrumental aspects of community support mobilise in times of necessity. Discussion of direct relevance to depression saw expansion upon this outcome as respect for and observance of the established demarcation of socially supportive family roles is seen as important as participants felt that others would defer to the primary importance of and desire for family privacy within their formulation of potential supportive responses. The depth of neighbourly relations appears of crucial importance as survey data reveals further uncertainty as respondents appeared underwhelmed by the potential responses of others in relation to their comfort in offering tangible, informational and caring support to those with depression. Such outcomes support the sentiments expressed within the interview data and are further endorsed upon consideration of both the survey and interview data pertaining to perceived stigma and within this, in particular, perceived social distance.

Implications

The present study had as its overarching ideological aim, the illumination of a socially imposed darkness via the discussion of what seemed an issue destined to remain shrouded in mystery and secrecy; the experience of depression and the social reaction to this in rural Irish society. Through the completion of this study it can be claimed that this broad aim has been achieved via engagement with rurally situated individuals and the provision of the opportunity and encouragement to discuss this sensitive topic. Further of this, the present research may be seen to hold implications in terms of theory and research which are discussed next.

In relation to the discourse pertaining to depression stigma existent in rural and indeed broader Irish society, as outlined in the *'Discussion of Findings'* chapter, the present study provides a clear case for a re-evaluation of the main outcomes which emerged from the important work discussing Irish attitudes to depression conducted over twenty years ago by McKeon and Carrick (1991), and thus the accepted low stigma association with the condition. The personal views offered in relation to those experiencing depression are similar in each study with, in consideration of potential issues of comparability, the present findings representing evidence of a slight improvement in personal attitudes in the twenty year period between studies. However, the vast differences between such personal outcomes and the perceived views of others in this regard encapsulated within the presently gathered perceived stigma and perceived social distance data suggests that until this point a key piece of

the puzzle of discrimination on the basis of experiencing depression has been overlooked; entrenched, culturally driven perceptions of the prejudices of others. This argument may also be made in relation to the Irish aspect within the recent work of Coppens *et al.* (2013). While the personal and perceived elements of stigma are addressed using a quantitative scale among a representative population with a trend of low personal and high perceived stigma emerging similarly to the present study though without the same level of extremes in either scale, failure to qualitatively explore the lived experience of a sample towards establishing factors which may be sustaining such perceptions must be seen to limit future attempts to improve the situation.

Further to the above point, appreciation of the novel, enriching, and informative nature of the findings in relation to the perceived views of others presented here in both qualitative and quantitative forms, also raises questions as to the non-inclusion of such an element within previous nationally and indeed internationally focused studies in this vein. In particular, on the basis of the richness of the views gathered within the present study, an approach seeking perceptions of the views held by others within qualitative data collection is to be encouraged.

In terms of the operationalization of stigma, the present study may be seen to assist in understanding the process of othering within this due to the detail offered in relation to the covert discussion of a socially salient attribute, in this case depression, and those linked or in the process of being linked to same. In particular, the above discussion of gossip provides significant detail in relation to how individuals and groups employ linguistics of strong symbolic value in order to delineate a human condition as outside of a defined normality, to link others to this attribute, and, more often, ultimately to ostracise such individuals.

Also in a methodological vein of interest, the present study demonstrates the value in the adoption of information communication technology (ICT) in order to include those populations designated 'hard to reach' within research. While not without some limitations as discussed further in the *'Study Limitations'* section below, employing this technology was essential to the success of this research as the response to and reach of the study facilitated by ICT utilisation exceeded expectation. Firstly, this strategy allowed for the accurate targeting of the desired study sample, while also providing great efficiency in terms of the dissemination of study materials, the recruitment process, and data collection. Complementing the snowball method superbly, this approach also delivered substantial cost savings in terms of potential travel and

materials. Secondly, and perhaps more importantly, utilising this technology also created the desired environment for the completion of the survey by respondents, i.e. in a distanced, faceless and non-judgemental environment, a key aspect of the study design formulated in an attempt to improve upon previous studies.

Contribution is also made to the discourse relating to the sociology of Ireland, and particularly rural Ireland. Further to the core findings in relation to the stigmatisation of depression, the considerable contributions of the study participants in their endeavours to articulate their views of their social environment provide an invaluable insight into the perceptions and lived experiences of those inhabiting contemporary rural Irish communities. Descriptions of a broadly restrictive and conservative rural social environment hold considerable importance for a modern understanding of this section of Irish society with the novelty of obtaining views in relation to issues of such traditional sensitivity adding to its significance and in itself perhaps indicative of social change. Further, in relation to the discourse on rural Irish community, the findings presented in relation to perceived social support may also be considered important due to their ability to challenge both the romanticised cohesive and the eroded individualised conceptions of community on the basis of a suggested compromise between both schools of thought. Also, in terms of the operationalization of social support, suggestion of its transformative potential within the discussion; the noted dynamism in a movement from belonging support to more instrumental forms of support upon the presence of need, is of keen interest within formulations of community support structures.

Recommendations

This study has raised a number of issues in relation to education, research, policy, and practice. Recommendations in relation to each of these aspects are presented below. These recommendations are grounded within the theory of stigma reduction which emphasise protesting against the acceptance of stigmatising attitudes, improving education in relation to the issue and the impact of stigma upon the social lives of those affected, and contact with those who come to be designated as the bearer of a stigma (Corrigan & Watson 2002).

Education

Noting the outlined historical absence of education in relation to mental health in Ireland, in moving toward increasing mental health literacy in the community (Jorm 2012), the discussion of depression and mental health should form an integral part of personal health education. Cognisant of the significant socialising role and influence of education (Adler *et al.* 1992), and the success of programs in this regard elsewhere (Skre *et al.* 2013), the development of strategies which promote the understanding of, and contact with depression and wider mental illness within both primary and second level education environments should be encouraged. Such strategies should aim to discuss mental health in an open manner and should contain an element in which the basic psychosocial impacts of stigmatisation in this regard are appreciated. Tuition should also include a component detailing and challenging historical and cultural considerations of depression and wider mental illness in order to raise awareness of the entrenchment of such erroneous views within society from an early age. Such tuition should be situated within the Social and Personal Health Education (SPHE) curriculum and amid discussions pertaining to wider health and wellbeing thus serving to include mental health as an intrinsic component of overall health. The opportunity for early social contact with those who experience depression exists in this instance as a programme in which appropriately trained individuals with experience of the condition deliver content could be considered.

Focusing upon young males in particular given their consistent mention within the data above in relation to their aversion to discussing mental health generally, though also including young females and incorporating a socially supportive community approach, pervasive community-based organisations such as, for example, the Gaelic Athletic Association (GAA), should be approached with a view to working on a coordinated approach with schools towards the raising of awareness of mental health issues among young people.

In order to sustain this awareness of mental health and wellbeing throughout the life course (WHO 2000), within third level education, greater emphasis should be placed upon the development of 'Sociology of Mental Health & Illness' modules across a range of relevant disciplines in which the historical and cultural understandings of same are detailed and challenged. Outside of this, third level environments should seek to promote awareness, especially among new entrants, of the need to address the stigmatisation of depression and mental illness. This can and is currently being

achieved through campus-wide initiatives such as 'Mental Health Week' etc.; however, one may argue that a more consistent approach is needed.

Further to the present findings and the work of Loebach Wetherell *et al.* (2009) for example, education programmes specifically directed towards older people should also be implemented. Cognisant of the traditional emphasis upon secrecy towards such matters, such programmes should aim to promote the open discussion and critique of historical and cultural attitudes towards mental health. Outside of targeting this education towards interest and community groups associated with older persons, noting their frequent value (Dumesnil & Verger 2009), a widespread informational campaign employing various media should also be implemented.

Research

Further research exploring the stigma towards depression and wider mental illness on an all-island level including rural, urban and suburban settings is required. While the present study has yielded substantial outcomes, one feels that a study employing a similar focus and methodology, but with the weight of greater resources and stature enjoyed by a large, nationally focused organisation may produce a more considerable piece of work than a lone researcher without such means. Maintaining the methodology employed presently would also promote greater public engagement, a key pillar within the work of the national stigma reduction campaign, *'Seechange'* (Seechange 2011).

A study exploring the stigmatisation of depression through a consideration of the lived experiences of those experiencing the condition in rural areas should be conducted. Adopting similar methods to those employed presently, this endeavour could provide the platform for the voices of those living under the highlighted veil of silence to be heard, while also providing a comparative work for the present general population study.

As suggested above, the present study has illustrated the value of seeking the perceptions of study participants in relation to what they feel are the views of others within their community. As argued in the *Research Methodology* chapter above, employing this technique yielded a number of benefits such as the creation of the potential for the distanciation of the participant from their views leading to a less confrontational interview process in relation to a subject evoking such sensitivity, an

appeasement perhaps of some of the concerns consistently raised in relation to the use of self-reported data, while in the same instance also providing valuable information to produce a portrait of experienced social life. Future studies should, building upon the work presented here, seek to harness this approach as a valuable investigative tool.

The present study supports the suggestion that Information Communication Technology is an immensely valuable tool in relation to increasing the inclusivity of research endeavours. Future research of this kind seeking to incorporate traditionally hard to reach cohorts, or indeed an all-island sample for example, should seek to harness the enormous potential for inclusion held by such technologies.

The outcomes of the present study lend considerable weight to the need for the undertaking of a similar and comparative study incorporating a sample of those living in urban and suburban Ireland. Such a study, while providing valuable information about the area and sample under consideration, would also provide a comparative piece for the present study thus enabling a greater consideration of the outcomes presented here.

Policy

Given its consistent mention across the present data, a review of past and present Catholic Church teaching policy in relation to mental illness and suicide should be undertaken. A formal statement in relation to these matters should be made to congregations in order to clarify the position of the Church in this regard.

In common with the views of O'Toole (2013) among others, the author feels the Irish State should establish a historical commission in order to explore the history of mental institutionalisation within the State with a view to providing an official narrative on the matter. In keeping with the educative strand of stigma reduction theory within which these recommendations are set, among a number of potentially beneficial outcomes of this process it is hoped that the stigmatisation associated with this issue may be addressed and with that the associated courtesy stigma towards depression and wider mental illness noted presently.

In line with the outcomes presented above and also with a strand of the work being undertaken within the national stigma reduction campaign *'Seechange'* (Seechange

2011), workplace based education programmes in which depression and wider mental illness and their presence in the working environment are discussed should become the responsibility of employers to implement alongside existing health and safety initiatives required by law.

Practice

In collaboration with similar agencies in Northern Ireland, cross-border, all-island strategies should be developed to challenge the stigma in relation to depression and wider mental illness.

Within the implementation of mental health focused anti-stigma strategies by government and/or non-governmental organisations, greater emphasis should be placed upon tackling the legacy of traditional understandings of depression as well as wider mental health and illness. Commencing with an acknowledgement of this legacy and an awareness of its consequences, initiatives should be put in place to publicly challenge the traditionally channelled common (mis)conceptions of these issues with a view to ending the dominance of thinking based upon, for example, demonology, with a view to replacing such views with those based within science.

The present study outcomes lend support to the extension of a recent anti-stigma campaign conducted by Amnesty International Ireland in which the impact of gossip in relation to suicide and mental illness, in particular its role in proliferating stigma and hampering potential recovery, was featured (SOS 2013).

Relevant agencies should develop initiatives which aim to stimulate public discourse and discussion in relation to the impact of stigma upon the outcomes of depression both for individuals and families, while also implementing a public awareness campaign in order to outline the benefits held by social support within the community for those experiencing depression.

Study Limitations

The present study holds a number of limitations which should be considered upon interpreting the findings.

Survey findings are based upon a non-probability sample of 174 individuals who identify themselves as residents of rural Ireland. As a result of this, one cannot estimate the statistical representativeness of this sample in terms of its demographic profile. Interview findings are based upon the views of 26 interview participants who were purposively sampled. Samples for both the survey and interview aspects are also self-selecting and thus the data yielded from each will inevitably reflect the views of those who felt comfortable to participate in research and discuss the subject matter.
Both the survey and interview sample emerged via the distribution of study materials to the affiliate membership of a national umbrella organisation for rural community groups, Irish Rural Link. As well as this membership typically containing socially active and aware individual rural dwellers, others within this membership, it emerged, worked or held backgrounds in community development. As a result of this, the views of the sample may be somewhat reflective of this perhaps more socially engaged cohort.

Though, according to the study design, the emphasis was continually placed upon seeking the perceptions of study participants in relation to the perceptions of others towards depression, frequently due to participants own personal exposure to or involvement with some form of depression, personally held opinions and attitudes came to the fore. Further, some study participants appeared to struggle with the concept of seeking their views on the perceptions held by others in society as opposed to the more common direct questioning of one's own attitudes and views. While every effort was made to limit confusion in this regard, some participants may potentially have provided statements which may not have reflected the participant's views accurately.

The implementation of a research design in which the use of ICT was central to engagement may have resulted in the potential exclusion of those unfamiliar with or lacking confidence in the use of such technologies and also those without the means (e.g. computer equipment or access to/ability to pay for internet) to receive such material. This aspect may be seen as accounting for the under representation of older persons within both the survey and interview samples as recent research details a lack of internet usage among this cohort (CARDI 2012).

Further to the above point, as outlined in Appendix One, the study sample was largely homogenous in terms of age, gender and educational attainment. The overall demographic profile of study participants in both aspects of the study reflects a predominantly young, english speaking, evidently computer literate, highly educated,

and working cohort. As a result of these factors, the present study must be seen to reflect the views of a small number of those identifying themselves as residents of rural Ireland and thus should not be generalised to reflect the wider rural community.

As discussed, the piloting of the interview aspect of the study was conducted concurrently with the main interview data collection phase, consequently the depth and length of some of the early interviews may have been compromised in parts as the author grew into the interviewer role.

Summary and Conclusion

This dissertation has explored the stigma associated with depression in rural Ireland. The symbolic interactionist framework implemented encouraged an emphasis upon symbolism both in relation to the operationalization of such stigma, but also within the exploration of the social and cultural factors deemed to contribute to its present existence. In terms of its contribution to the discourse on depression stigma, the work presented here has facilitated a better consideration of the level of stigma existent via moving to appreciate the value of gaining an understanding as to the level of stigma perceived to be held by others in society in this regard. This has been achieved through placing the consideration of the stigmatising views, desires for social distance, and attitudes towards social support availability perceived to be held by others in the community as central to the research endeavour.

It is clear that study participants view a social environment in which the experience of depression is most likely to be accompanied by the imposition of a stigma upon the individual and, indeed, often their family also. This stigma is deemed characterised by perceptions that the individual involved is seen to be in a sense of denial, the holder of some inherent perhaps family acquired weakness, viewed to be disabled within wider society, and the likely recipient of measures of social distancing and exclusion instigated by those both within and beyond their community. Going beyond this, such an individual is also seen to be perceived to engender fear in others; both in the sense that they may potentially pose a physical threat to others, but also the suggestion that close association with such an individual may ultimately trigger the degradation of their and one's own mental wellbeing. That, consequently to these aspects, a culture of secrecy around depression is perceived to exist, and that the above elements of stigmatisation and this same culture are perceived to be supported and driven by entrenched social norms and traditions, and by powerful social institutions, holds

tremendous implications in terms of the proliferation of such social conditions. Mindful of these aspects, in particular the stated culture of secrecy said to persist, that the present study succeeded in opening the discussion of these matters in this setting may be seen to have implications for future research in this area.

In *'The Depression Report'* published in the UK in 2006, Professor Richard Layard describes depression as a "great submerged problem, which shame keeps out of sight" (LSEPS 2006, p. 1). Upon consideration of the findings of the research presented above, one may contend that this sentiment is also applicable to the status of the condition in contemporary rural Ireland. It is hoped that through exposing this forcefully concealed aspect of rural Irish society, illuminating an area heretofore bathed in socially imposed darkness, this work may contribute to the gradual erosion of the association of disgrace with the experience of depression thus assisting in the global effort to bring the issue to the surface and facilitating a greater understanding, through which compassion and progress of thought and behaviour may emerge.

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Appendices

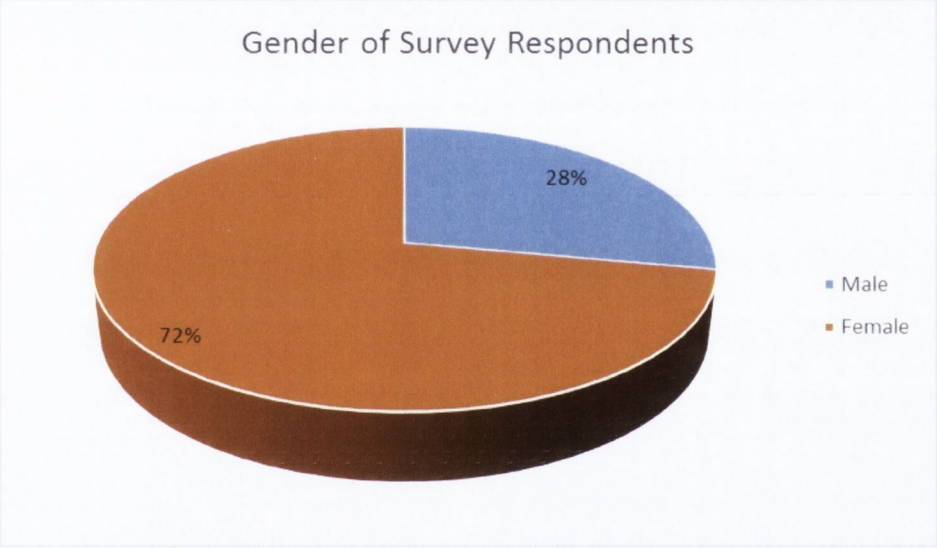
Appendix One - Demographic Profile of Participants

A total of 174 persons completed the survey element of the study while interviews were conducted with 26 participants.

Survey Sample

Gender Identity

Figure A1: Gender of Survey Respondents



Age Distribution

The average age of survey respondents is noted as 41.04 years (SD= 12.50, range= 59 years). The range of ages of those who took part spans 18 to 77 years.

Figure A2: Age Profile of Survey Respondents

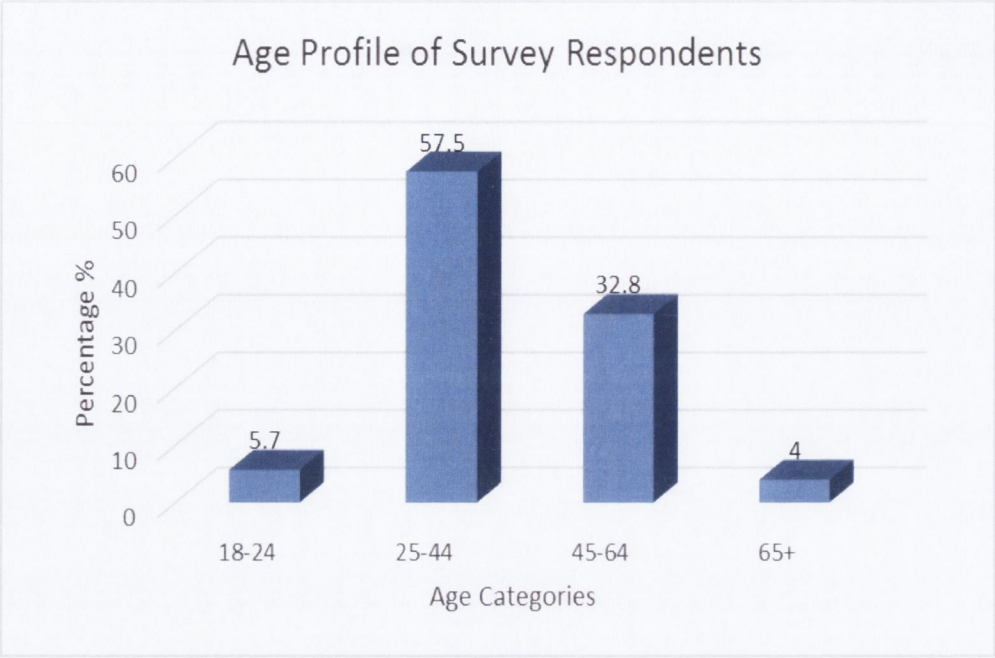


Table A1: Age and Sex of Survey Respondents

		Sex of Respondent		Total
		Male	Female	
Age Categories	18-24 Years	2	8	10
	25-44 Years	24	76	100
	45-64 Years	19	38	57
	65+ Years	4	3	7
Total		49	125	174

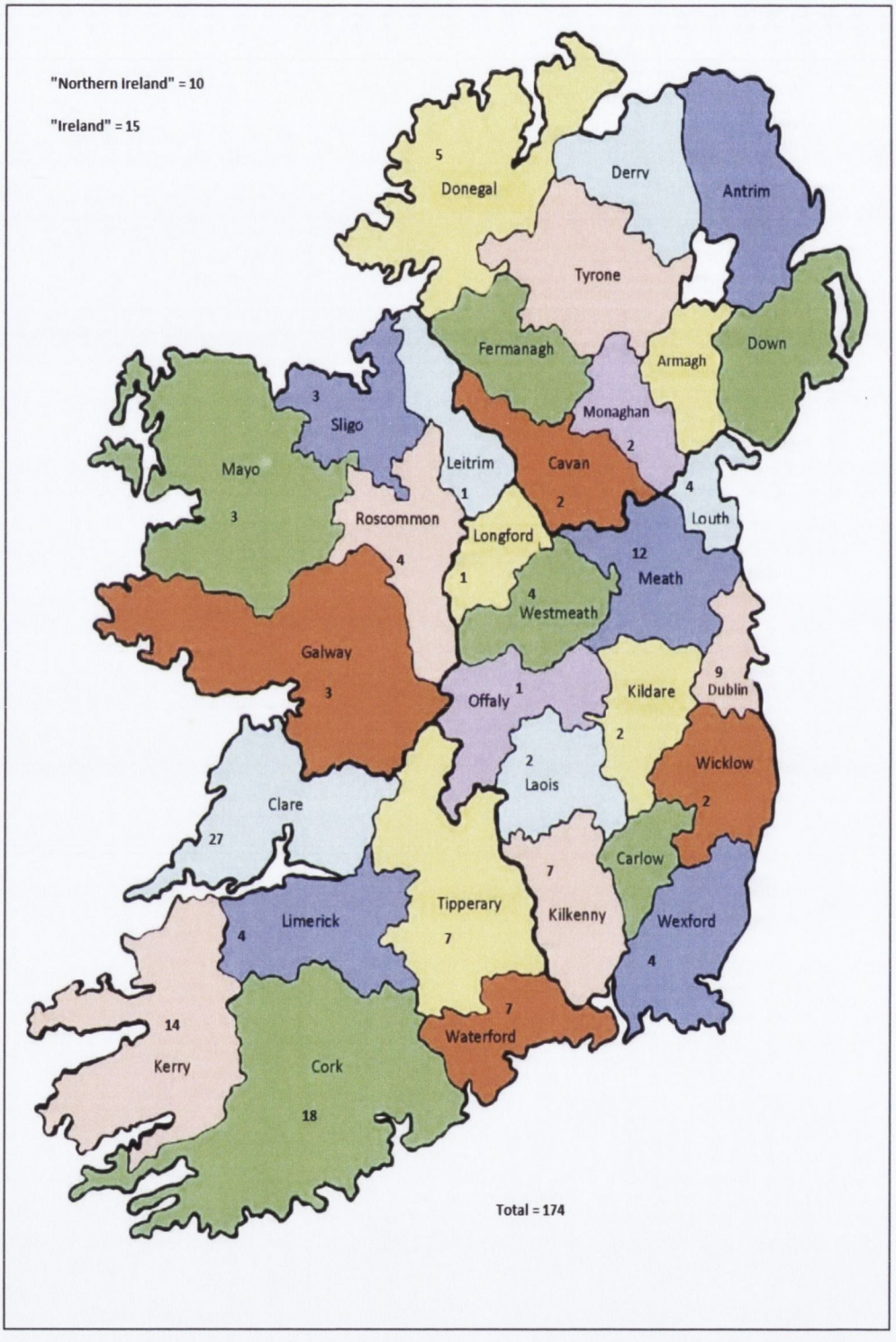
County of Residence

Respondents to the online survey stated their residence within twenty-five different counties across the Republic of Ireland accounting for 149 of the 174 surveys completed. Reflecting perhaps a misreading of the question or an unwillingness to detail ones location, a number of other respondents entered data which did not

correspond to counties within the Republic and were thus placed in two appropriate categories prior to analysis. The category 'Ireland' (n= 15) was used for those who had (perhaps mistakenly) entered the term *'Ireland'* into the section where one's county of residence was sought, while similarly the category of 'Northern Ireland' (n= 10) was used for those respondents who inserted the term *'Northern Ireland'* or the name of a county within the six counties which comprise Northern Ireland.

Figure A3 below graphically presents the counties from which survey responses emerged from and the number of responses per county.

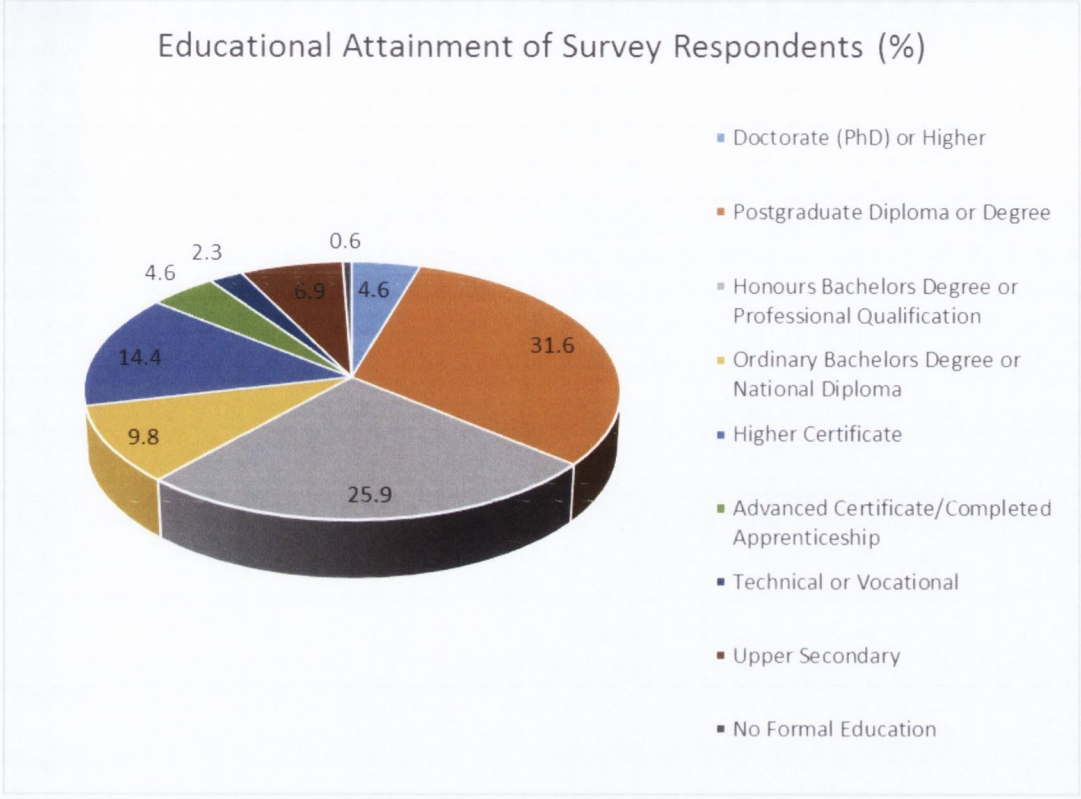
Figure A3: Survey Respondents County of Residence



Source of Map: http://www.irish-genealogy-toolkit.com/image-files/mapofcountiesofireland98kb.jpg

Highest Level of Education

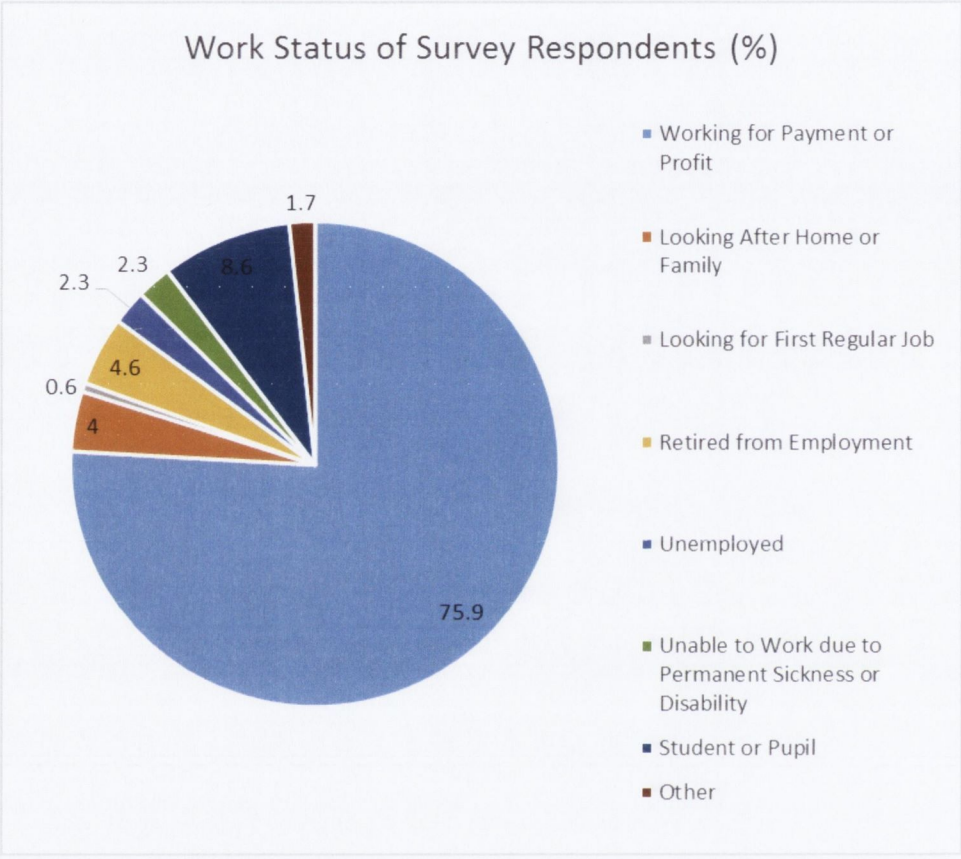
Figure A4: Survey Respondent Educational Attainment



Work Status

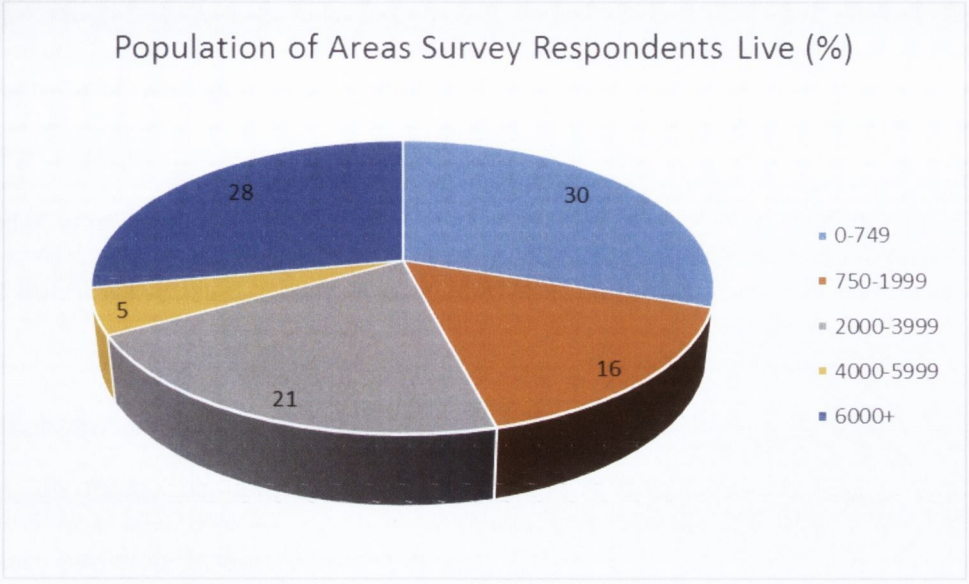
Adopting a measure used in the Census of Ireland 2011 (CSO 2012), respondents were asked to provide detail of their principal status.

Figure A5: Survey Respondent Principal Status



Population Categories

Figure A6: Survey Respondent Population Categories

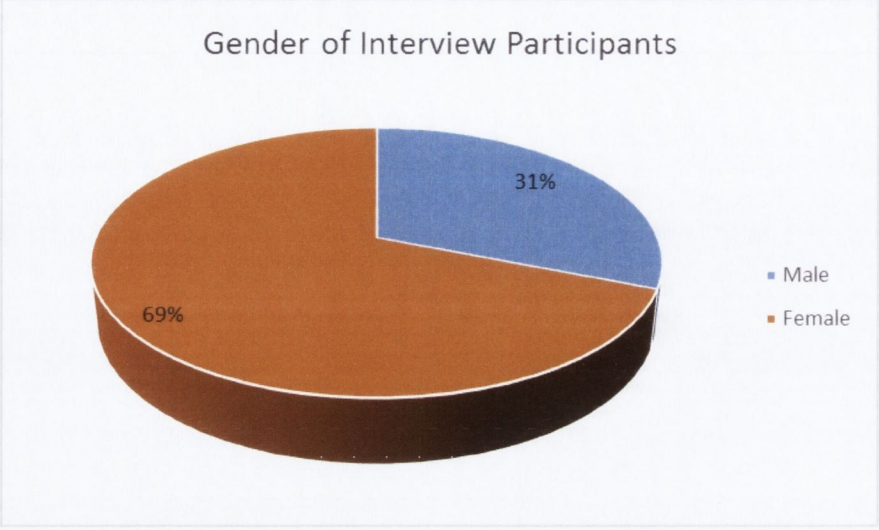


Interview Sample

Twenty-six face-to-face interviews were conducted. As prospective participants had two options to register their interest in taking part, following completion of the survey and without completing the survey, 23 of those interviewed had completed a survey while 3 participants registered for interview only. As a result of this, a small amount of data is absent as some questions were not covered during the course of the interview with those who had not completed a survey prior to interview.

Gender

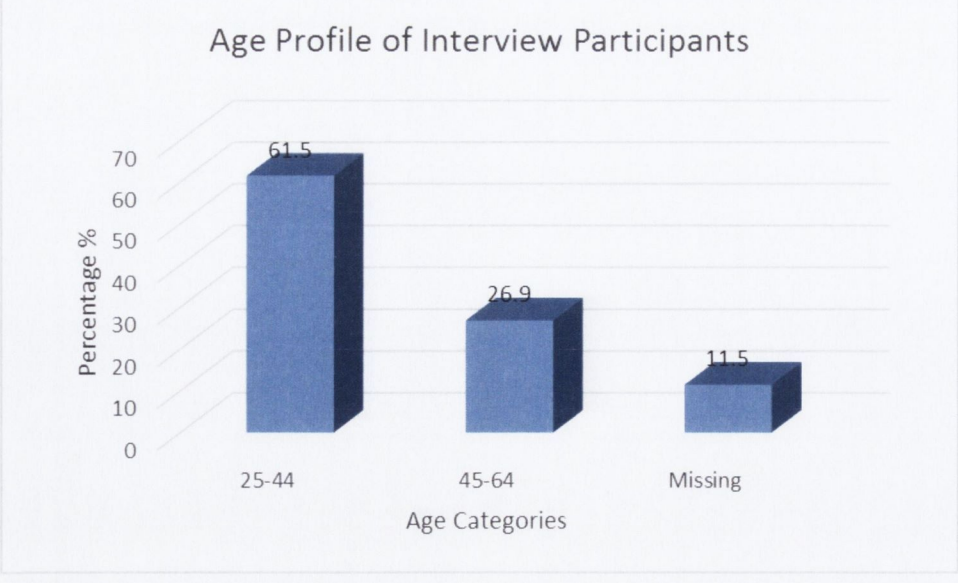
Figure A7: Gender of Interview Participants



Age Profile

Of the 23 interview participants for which age data is available, the mean age was 42.87 years (SD=11.279). The youngest interviewee was 25 years old and the eldest participant was 61 years old.

Figure 8: Age Profile of Interview Participants



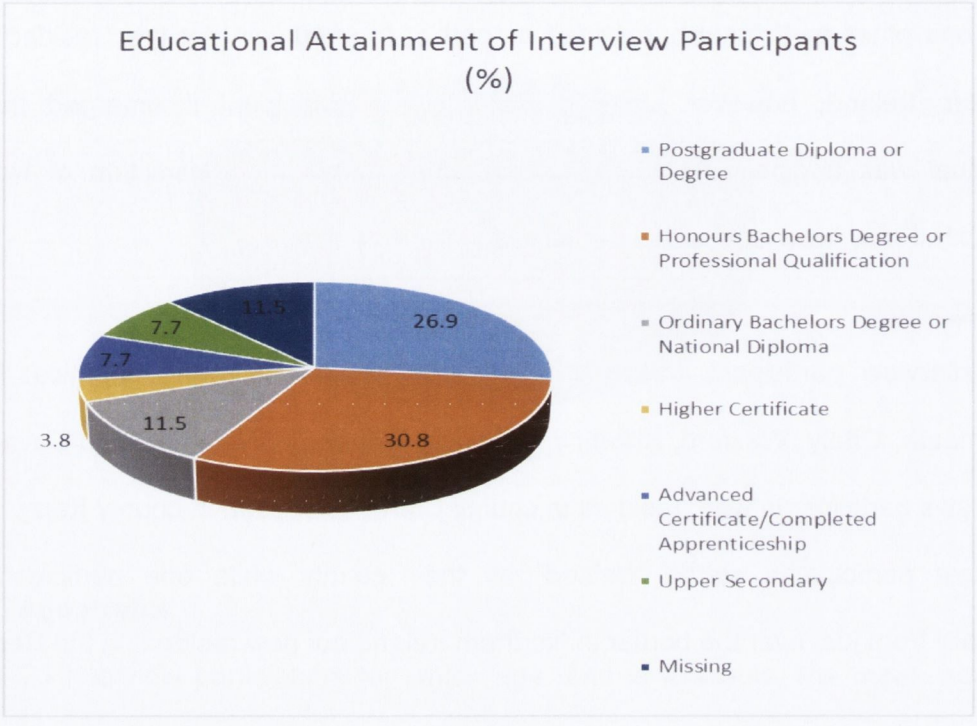
County of Residence

Twenty-six interview participants originated from 11 counties across the Republic of Ireland. Three participants emerged from the category which was labelled 'Ireland' while one other participant had stated as part of their survey that they resided within Northern Ireland, however, upon contacting this participant it emerged that the individual was originally from the border region within the jurisdiction of Northern Ireland but now lived just across the border in the Republic.

One interview participant was resident in each of the following counties: Meath, Westmeath, Offaly, Wexford, Kilkenny, Limerick, Tipperary, Waterford and Cavan. Six interviews participants were resident in county Clare, and seven in county Kerry. Three interview participants stated "Ireland" as their county while one participant was originally from just over the border in Northern Ireland but now resident in the Republic.

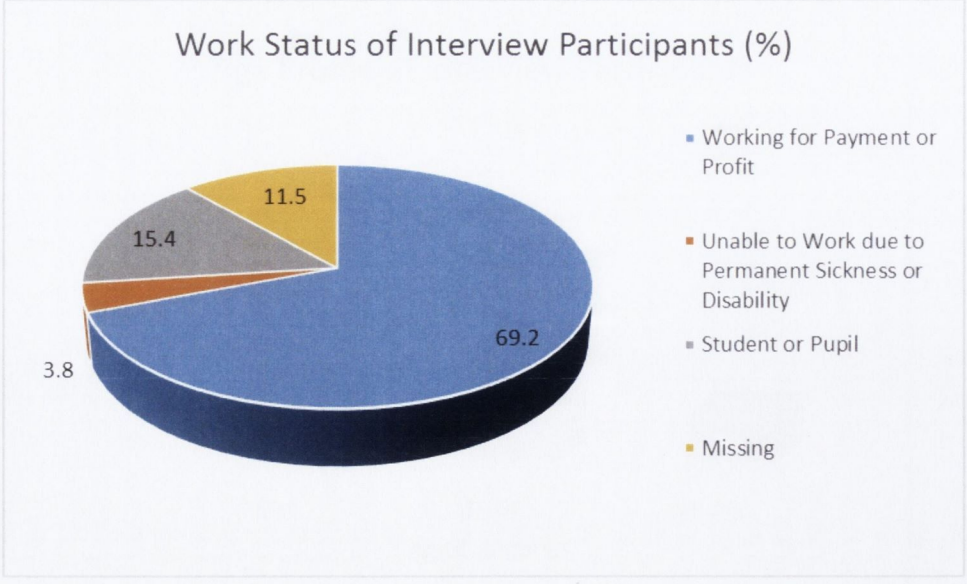
Highest Level of Education

Figure A9: Highest Educational Achievement of Interview Participants



Work Status

Figure 10: Work Status of Interview Participants



Appendix Two – Study Email

Dear Sir or Madam,

Further to an email you may have received last week, I am conducting research as part of a PhD programme in Trinity College Dublin with my research aim being to explore perceptions of depression in Ireland.

Survey: I would like to invite you to complete this brief survey online at https://www.surveymonkey.com/XXXXXXX.

Before you do so, please see the attached information leaflet for further details on the study. The survey will take just a couple of minutes to complete, is anonymous & confidential, however, you must be **over 18 years** of age to take part.

Interview: I am also hoping to interview some of those interested in discussing the topics raised further. If you are interested in being interviewed, please choose to 'opt-in' at the end of the survey and follow the directions. Alternatively, you can also register your interest in being interviewed without completing the survey by emailing XXXXXX@tcd.ie or by clicking the following link and inputting your details: https://www.surveymonkey.com/XXXXXXXXX. **Please see the attached research study information leaflets for further details.**

**** Please pass on this email in its entirety and with the attachments to others within your organisation/network/friends and family.** **

Your help in either completing the questionnaire online, or taking part in an interview, or both is vital to the success of this research and would be very much appreciated.

Should you wish to contact me in relation to any aspect of the research, please feel free to contact me by email at XXXXXX@tcd.ie or by phone at (085) XXXXXXX. Alternatively, you could contact the study supervisor, Dr. Edward McCann at Trinity College Dublin on XXXXXXX@tcd.ie or by phone at (01) XXXXXXX.
Is mise le meas,

Conor Kennedy MA
Supervisor: Dr. Edward McCann, School of Nursing & Midwifery, Trinity College Dublin.

Appendix Three – Survey Information Leaflet

IRL-TCD RURAL DEPRESSION ATTITUDES STUDY

Information Leaflet - Questionnaire

1. Title of study: Exploring stigma towards depression and its impacts upon access to social resources in Ireland.

2. Researchers: Mr. Conor Kennedy MA. & Dr. Edward McCann (Supervisor).

3. Introduction: This study aims to gain a better understanding of public perceptions in relation to depression and how this may impact on the way people interact in Irish communities. To achieve this insight, I would like to kindly request your participation in this research. I would greatly appreciate if you could assist me by answering the brief questionnaire online at https://www.surveymonkey.com/XXXXXXX. The questionnaire will not take more than 10 minutes to complete.

4. Procedures: To take part, participants must be over 18 years of age. Participants are invited to complete the brief questionnaire online at https://www.surveymonkey.com/XXXXXXX. All information provided will be completely confidential and at no point will information be sought that may identify you.

5. Benefits: The subject of depression is quite topical both nationally and internationally at present and it is hoped that the outcomes of this research will contribute to future policy in relation to depression in Ireland. The results of the research will be compiled and presented in a report as part of a PhD submission in Trinity College Dublin. Aspects of the results may also form the basis of academic papers which may be considered for publication in peer review journals at a later point.

6. Risks: Your wellbeing is of paramount importance. It is not anticipated or intended that completing the questionnaire would cause any undue upset or discomfort to participants. However, if you experience any discomfort during any stage of the questionnaire you may of course pause, postpone or end entirely your participation in the research study. Should you feel any distress the following national helplines are available to assist you:

Samaritans (1850 60 90 90), Aware Helpline (1890 303 302).

7. Exclusion from participation: Unfortunately, you cannot participate in this study if you are under 18 years of age.

8. Confidentiality:

As stated above, your identity will remain completely confidential. Your name will not be published anywhere and will not be disclosed to anyone. All data will be stored in compliance with the Data Protection (Amended) Act 2003.

9. Compensation:

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

10. Voluntary Participation: If you decide to volunteer to participate in this study, you may withdraw at any time.

11. Stopping the study: You understand that the investigators may withdraw your participation in the study at any time without your consent.

12. Permission: This study has received ethical approval from the Research Ethics Committee of the Health Science Faculty of Trinity College Dublin.

13. Further information: You can get more information in relation to the study, your participation in the study, and your rights, from Conor Kennedy who can be contacted at (085) XXXXXXX or emailed at XXXXXX@tcd.ie. You can also contact the study supervisor Dr Edward McCann by calling (01) XXXXXXX or by emailing XXXXXX@tcd.ie . If the study team learns of important new information that might affect your desire to remain in the study, you will be informed at once.

Appendix Four – Interview Information Leaflet

IRL-TCD RURAL DEPRESSION ATTITUDES STUDY

Information Leaflet - Interview

1. Title of study: Exploring stigma towards depression and its impacts upon access to social resources in Ireland.

2. Researchers: Mr. Conor Kennedy MA. & Dr. Edward McCann (Supervisor).

3. Introduction: This study aims to gain a better understanding of public perceptions in relation to depression and how this may impact on the way people interact in Irish communities. I would be very appreciative if you would agree to share your views on this subject through taking part in an interview.

4. Procedures: To take part, participants must be over 18 years of age. The interview will take place at a place and time of your choice. With your consent, the interview will be audio recorded, however, your identity, contact details and the content of the discussion will be completely confidential and robust measures, in full compliance with Data Protection laws, will be used to ensure this. All information provided during the discussion will be completely anonymous and at no point during the interview will information be sought that may identify you. If you wish, you will be given access to the transcripts of the interview.

5. Benefits: The subject of depression is quite topical both nationally and internationally at present and it is hoped that the outcomes of this research will contribute to future policy in relation to depression in Ireland. The results of the research will be compiled and presented in a report as part of a PhD submission in Trinity College Dublin. Aspects of the results may also form the basis of academic papers which may be considered for publication in peer review journals at a later point.

6. Risks: Your wellbeing is of paramount importance. It is not anticipated or intended that completing the interview would cause any undue upset or discomfort to participants. However, if you experience any discomfort during any stage of the questionnaire you may pause, postpone or end entirely your participation in the

research study. Should you feel any distress the following national helplines are available to assist you: Samaritans (1850 60 90 90), Aware Helpline (1890 303 302).

7. Exclusion from participation: Unfortunately, you cannot participate in this study if you are under 18 years of age.

8. Confidentiality:

As stated above, your identity will remain completely confidential. Your name will not be published anywhere and will not be disclosed to anyone. All data will be stored in compliance with the Data Protection (Amended) Act 2003.

9. Compensation:

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

10. Voluntary Participation: If you decide to volunteer to participate in this study, you may withdraw at any time.

11. Stopping the study: You understand that the investigators may withdraw your participation in the study at any time without your consent.

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Appendix Five – Semi-Structured Interview Schedule

Opening of Interview: Please tell me something about yourself, where you are from, what you do...

Topic Guide:

- Perceived community knowledge of depression – manifestation, causes, and treatment possibilities.
- Origins of community knowledge of depression.
- Relationships with those with depression.
- Perceived hypothetical comfort/discomfort of others with those with depression – friend, colleague etc...
- Views on stigma attached to depression.
- Depression seen as a form of weakness?
- Understood local rural community responses to depression/mental health issues.
- Depression as source of gossip in rural communities - familiarity with colloquial terms for depression.
- Perceived local knowledge and origins of above.
- Practical responses to depression stigma in the community – social distancing?
- Perceived practical (day-to-day), social and professional implications of potential discrimination.
- Implications for potential individual social support structures.

Example of Probes:

- And why do you think that is?
- What do you think might be driving this behaviour/thinking?
- Can you think of any instances of this in your own community?
- That's really interesting, have you any other examples of this?

Conclusion of Interview:

- Offer opportunity to revisit all aspects of interview.
- Reiterate researcher contact details.
- Ask if any queries about any aspect of the study/their participation.
- Thank for participation.

Appendix Six – Questionnaire Survey

TCD Rural Depression Attitudes Survey

***1. Sex:**

○ Male ○ Female

***2. What is your age?**

***3. What county do you live in?**

***4. What is the APPROXIMATE population of the area (e.g. village, town, townland) in which you live?**

***5. How would you describe your present principal status?**
Please tick ONE of the following boxes.

○ Working for payment or profit ○ Unemployed

○ Looking after home/family ○ Unable to work due to permanent sickness or disability

○ Looking for first regular job ○ Student or pupil

○ Retired from employment ○ Other

Other (please specify)

6. If you are working, unemployed or retired, what is/was your occupation in your main job? (If any other option, please continue to next question)

TCD Rural Depression Attitudes Survey

***7. Please read the following statements and select ONE of the five options which most accurately reflects how you feel about each statement.**

	Disagree Strongly	Disagree Somewhat	Neutral	Agree Somewhat	Agree Strongly
People with depression could snap out of it if they wanted.	◯	◯	◯	◯	◯
Depression is a sign of personal weakness.	◯	◯	◯	◯	◯
Depression is not a real medical illness.	◯	◯	◯	◯	◯
People with depression are dangerous.	◯	◯	◯	◯	◯
It is best to avoid people with depression so you don't become depressed yourself.	◯	◯	◯	◯	◯
People with depression are unpredictable.	◯	◯	◯	◯	◯
If I had depression I would not tell anyone.	◯	◯	◯	◯	◯
I would not employ someone if I knew they had been depressed.	◯	◯	◯	◯	◯
I would not vote for a politician if I knew they had been depressed.	◯	◯	◯	◯	◯

TCD Rural Depression Attitudes Survey

***8. Please read the following statements and select ONE of the five options which most accurately reflects how you feel about each statement.**

	Disagree Strongly	Disagree Somewhat	Neutral	Agree Somewhat	Agree Strongly
MOST PEOPLE believe that people with depression could snap out of it if they wanted.	○	○	○	○	○
MOST PEOPLE believe that depression is a sign of personal weakness.	○	○	○	○	○
MOST PEOPLE believe that depression is not a real medical illness.	○	○	○	○	○
MOST PEOPLE believe that people with depression are dangerous.	○	○	○	○	○
MOST PEOPLE believe that it is best to avoid people with depression so you don't become depressed yourself.	○	○	○	○	○
MOST PEOPLE believe that people with depression are unpredictable.	○	○	○	○	○
If they had depression, MOST PEOPLE would not tell anyone.	○	○	○	○	○
MOST PEOPLE would not employ someone they knew had been depressed.	○	○	○	○	○
MOST PEOPLE would not vote for a politician they knew had been depressed.	○	○	○	○	○

***9. Please fill in the gap in the sentences below by selecting ONE of the options which most accurately reflects how you feel about each statement.**

	Very Easy	Easy	Uncertain	Difficult	Very Difficult
Most people would find it _____ to provide information or advice to someone with depression.	○	○	○	○	○
Most people would find it _____ to provide help or assistance with household tasks or errands to someone with depression.	○	○	○	○	○
Most people would find it _____ to provide love, care, understanding and reassurance to someone with depression.	○	○	○	○	○

TCD Rural Depression Attitudes Survey

***10. Please read the following statements and select ONE of the five options which most accurately reflects how you feel about each statement.**

	Disagree Strongly	Disagree Somewhat	Neutral	Agree Somewhat	Agree Strongly
Most people would be willing to start work with a person with depression.	○	○	○	○	○
Most people would not mind moving next door to a person with depression.	○	○	○	○	○
Most people would have no problem making friends with a person with depression.	○	○	○	○	○
Most people would happily rent a room to a person with depression.	○	○	○	○	○
Most people would be happy to recommend a person with depression for a job if they were qualified for it.	○	○	○	○	○
Most people would not mind their child marrying a person with depression.	○	○	○	○	○
Most people would trust someone with depression to care for their child.	○	○	○	○	○

TCD Rural Depression Attitudes Survey

***11. Please read the following statements and tick ONE of the five options which most accurately reflects how you feel about each statement.**

	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
Most people would view someone with depression as immoral.	◯	◯	◯	◯	◯
Most other people would view depression as due to unhealthy lifestyle choices.	◯	◯	◯	◯	◯
Most other people would view depression as due to lack of spirituality.	◯	◯	◯	◯	◯
Most people would go out of their way to include someone with depression socially.	◯	◯	◯	◯	◯
Most people would trust someone with depression less than someone without depression.	◯	◯	◯	◯	◯
Someone with depression is likely to be the subject of gossip locally.	◯	◯	◯	◯	◯
Local community organisations are open to membership for persons with depression.	◯	◯	◯	◯	◯

12. In the last year or so, have you heard the following terms used to describe depression?

	Yes	No
"S/he is suffering with his nerves..."	◯	◯
"S/he is a bit touched..."	◯	◯
"S/he is not well from time to time..."	◯	◯

13. Do you think most other people act differently towards someone whom they know to have depression?

☐ Yes ☐ No ☐ Not sure

Other (please specify)

TCD Rural Depression Attitudes Survey

***14. What is the highest level of education you have completed to date?**

Please tick ONE of the following boxes.

- ◯ No Formal Education/Training
- ◯ Primary Education
- ◯ Lower Secondary Education
- ◯ Upper Secondary Education
- ◯ Technical or Vocational
- ◯ Advanced Certificate/Completed Apprenticeship
- ◯ Higher Certificate
- ◯ Ordinary Bachelors Degree or National Diploma
- ◯ Honours Bachelor Degree or Professional Qualification
- ◯ Postgraduate Diploma or Degree
- ◯ Doctorate (PhD) or higher

15. If you are interested in taking part in an interview to discuss the topics raised here further, please fill in your details below, then click 'DONE' below.

If you are not interested, please click 'DONE' below to complete the survey:

Email Address:

Phone Number:

Appendix Seven - Participant Consent Form for Interview

PROJECT TITLE: Exploring stigma towards depression and its impacts upon access to social resources in Ireland.

PRINCIPAL INVESTIGATORS: Mr. Conor Kennedy MA, Dr. Edward McCann & Dr. Damien Brennan

BACKGROUND:

This aspect of the study aims at learning more about your opinions in relation to stigma towards depression in Irish society. To achieve this, you will be asked a series of questions in relation to the topic and asked to give your honest personal opinions. With your consent, the interview will be audio recorded. Your identity, contact details and the content of the discussion will be completely confidential and robust measures, in full compliance with Data Protection laws, will be used to ensure this.

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME: .....

CONTACT DETAILS: .....

PARTICIPANT'S SIGNATURE: .....

Date:.....

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:..... **Date:**.....